July 2004

Dear Sandia Intermediate PPO Plan Participant:

Our records show that you are enrolled in the Sandia Intermediate PPO Plan. The information provided in this letter is a summary of material modifications as well as clarifications to the current Sandia Intermediate Summary Plan Description (SPD), dated January 1, 2003, and should be kept as a supplement with your Sandia Intermediate PPO SPD.

The following changes in the Prescription Drug Program copayments became effective January 1, 2004:

- Page A-1, under **Prescription Drug Program,** please replace the copayments as follows.

  Prescription copayments changed as follows:

	2003 Copayments	2004 Copayments
EHS Network Pharmacies Maximum 30-day supply	• Generic prescription drugs - Coinsurance 20% of retail discount price with a $6 minimum and a $9 maximum • Preferred formulary brand-name prescription drugs - Coinsurance of 30% of retail discount price with a $17 minimum and $27 maximum • Non-preferred brand-name prescription drugs – Coinsurance of 40% of retail discount price with a $30 minimum and a $40 maximum.	• Generic prescription drugs - Coinsurance 20% of retail discount price with a $6 minimum and a $9 maximum • Preferred formulary brand-name prescription drugs - Coinsurance of 30% of retail discount price with a $17 minimum and $32 maximum • Non-preferred brand-name prescription drugs – Coinsurance of 40% of retail discount price with a $30 minimum and a $50 maximum.
Mail-Order Program Maximum 90-day supply	• $12 for generic prescription drugs • $38 for preferred formulary brand-name	• $13 for generic prescription drugs • $43 for preferred formulary brand-name

(for maintenance prescription drugs)	prescription drugs • $68 for nonpreferred brand-name prescription drugs	prescription drugs • $75 for nonpreferred brand-name prescription drugs

The following are clarifications to the current Sandia Intermediate PPO SPD:

The first Note on page 3-2 of the Sandia Intermediate PPO SPD reads "If your effective date is prior to the 16th of the month, you will be required to pay the applicable cost-share amount for the month in which you were hired or reclassified. If your effective coverage date is after the 15th of the month you will not be required to pay the cost-share amount for the month in which you were hired or reclassified." **The corrected version is:** "If your effective date is prior to the 17th of the month, you will be required to pay the applicable cost-share amount for the month in which you were hired or reclassified. If your effective coverage date is after the 16th of the month you will not be required to pay the cost-share amount for the month in which you were hired or reclassified."

Page 2-5 Class II Dependents: unmarried step-children and step-parents are also eligible for Class II coverage. A signed affidavit that the Class II dependent meets the eligibility criteria is required to enroll a Class II dependent.

Addition to the eligibility criteria:

Domestic partner who meets all of the following criteria:

- Must be a domestic partner of a nonrepresented, OPEIU- or SPA-represented employee (retirees and other employees are not eligible to enroll domestic partners and/or domestic partner dependents),
- Is the same gender as the employee,
- Shares significant financial resources and dependencies,
- Has resided with the employee continuously for at least six months in a sole-partner relationship that is intended to be permanent,
- Is unmarried,
- Is not related to employee by blood (e.g., brothers, sisters, parents, children, cousins, nieces, uncles),
- Is at least 18 years of age, and
- Has complied with all Sandia requirements for verification of domestic partner eligibility.

Note: Contact the Sandia BCSC at 505-845-2363 to request the enrollment packet or go to Sandia's Domestic Partner webpage at http://www-irn.sandia.gov/hr/benefits/ domesticpartner/ index.htm for the packet, which contains information on enrolling domestic partner dependents, including affidavit and enrollment forms, documentation requirements, and tax implications.

Unmarried child of your domestic partner under age 19 (see Appendix B for definition of "child");

Unmarried child of your domestic partner age 19 and over, but under age 24 who is financially dependent on you; and

Unmarried child of your domestic partner of any age, who, because of a physical handicap or mental impairment, including mental illness:

- Is incapable of self-sustaining employment,
- Lives with you (the covered participant) or in an institution or in a home you provide, **and**
- Is financially dependent on you, the covered participant.

Sandia National Laboratories
A Department of Energy National Laboratory

Sandia Intermediate PPO

Summary Plan Description

Effective: January 1, 2003

SAND 2004-2783 W

Sandia Intermediate PPO

When you or covered family members need medical care, the Sandia Intermediate Preferred Provider Organization (PPO) Plan (referred to as Intermediate PPO) provides valuable financial protection. The Intermediate PPO consists of two options: an in-network PPO option and an out-of-network non-PPO option. This booklet provides medical benefit information to help you make more informed decisions when you or your family use this Plan. The Plan also includes the Behavioral Health Program, the Employee Assistance Program, Family Planning, and the Prescription Drug Program.

As an alternative to the Intermediate PPO, the Sandia Basic PPO Plan and the Sandia Top PPO Plan are offered worldwide. The CIGNA Network POS Plan is offered in New Mexico, Nevada, Washington, D.C., Maryland, northern Virginia, and northern California, and the Kaiser HMO in California. These are described in their individual Summary Plan Descriptions.

As a member in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income and Security Act (ERISA) of 1974. This information, as well as certain general information concerning the Plan, is included as a separate booklet in your *Sandia Employee Benefits Binder* and is called "ERISA Information."

The Intermediate PPO is a self-insured plan for eligible insureds (page 1-1) of Sandia Corporation, PO Box 5800, Albuquerque, New Mexico, 87185 (employer identification number 85-0097942, plan number 519). This Plan is administered on a calendar year basis from January 1 through December 31 for accumulation of maximums, deductibles, claim filing, and filing of reports to the Department of Labor. United of Omaha, the Claims Administrator, has assigned the following group plan number: **G0003E76**. For information concerning service of legal process, contact the Sandia Legal Division, Sandia National Laboratories, PO Box 5800, MS 0141, Albuquerque, New Mexico, 87185.

The information contained in this Summary Plan Description is provided in accordance with the requirements of the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code.

Sandia complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), Pub. L. 104–191, that was enacted on August 21, 1996. HIPAA amended the Public Health Service Act (PHS Act), the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue

Code of 1986 (Code) to provide for, among other things, improved portability and continuity of health insurance coverage in the group and individual insurance markets, and group health plan coverage provided in connection with employment. The HIPAA provisions are designed to improve the availability and portability of health coverage not limited to the following:

- Limiting exclusions for preexisting medical conditions
- Providing credit for prior health coverage and a process for transmitting certificates and other information concerning prior coverage to a new group health plan or issuer
- Providing new rights that allow individuals to enroll for health coverage when they lose other health coverage or have a new dependent
- Prohibiting discrimination in enrollment and premiums against employees and their dependents based on health status

This Summary Plan Description summarizes the Intermediate PPO operations, benefits, claim filing procedures, and other Plan provisions. Copies of this document and other Summary Plan Descriptions are available from your Sandia Corporation (Sandia) Benefits office.

The Sandia Intermediate PPO is maintained at the discretion of Sandia and is not intended to create a contract of employment and does not change the at-will employment relationship between you and Sandia. The Sandia Board of Directors (or designated representative) reserves the right to change or amend any or all provisions of the Intermediate PPO, and to terminate the Intermediate PPO at any time without prior notice, subject to applicable collective bargaining agreements. If the Intermediate PPO should be terminated or changed, it will not affect your right to any benefits to which you have already become entitled.

This page intentionally left blank.

Contents

APPENDICES

Section 1

Highlights

Summary of Plan Changes

- Medicare-primary retirees are subject to copays, coinsurance, deductibles, and out-of-pocket maximums (please see pages 4-1, and 5-1 through 5-7).
- Once the out-of-pocket maximum has been met, coordination with Medicare will be at 100% of U&C charges.
- Pre-existing conditions for Class II dependents have been removed.
- Effective April 1, 2003, the on-site Sandia Employee Assistance Program (EAP) will not be a part of the Intermediate PPO. The on-site EAP services will be provided by Sandia Medical Services. You will still receive the benefit of eight visits at no charge to off-site EAP providers.

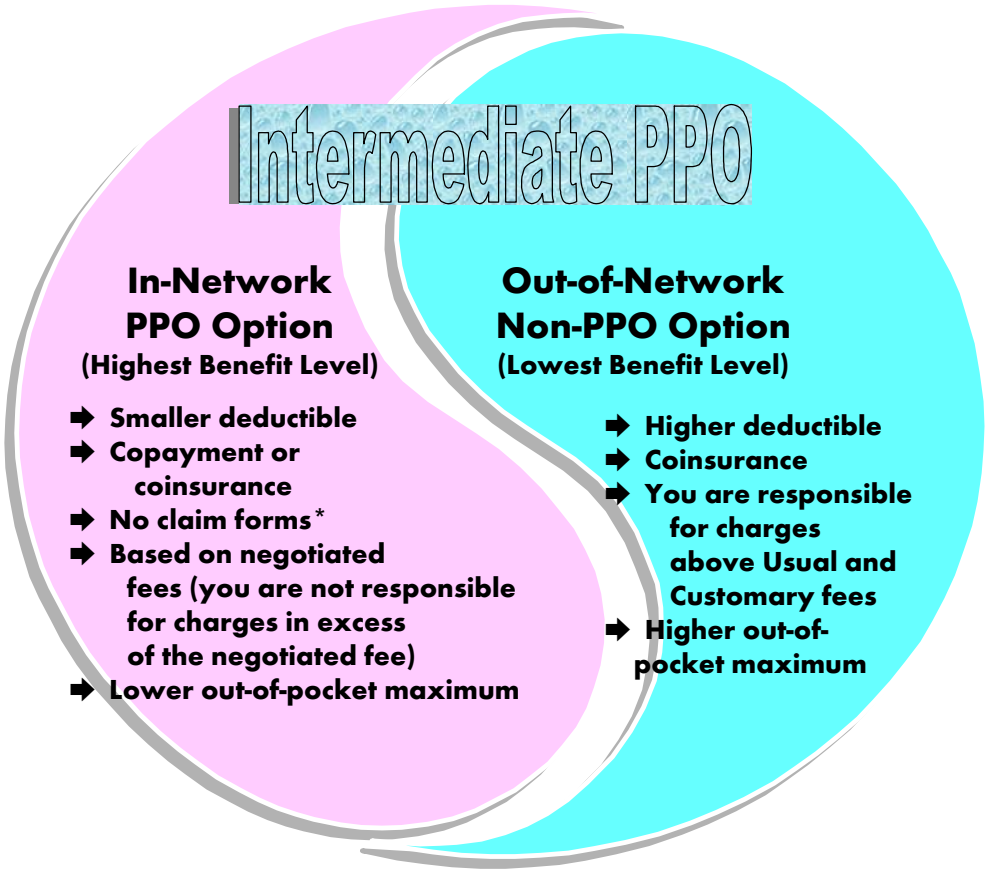
Changes in the Prescription Drug Program

- Mail-order copays
  - Preferred formulary brand-name copay has changed from $34 to $38 for a 90-day supply.
  - Non-preferred brand-name copay has changed from $60 to $68 for a 90-day supply.
- Retail pharmacy copays
  - Maximum copay for generic has changed from $8 to $9.
  - Maximum copay for preferred brand-name has changed from $21 to $27.
  - Maximum copay for non-preferred brand-name has changed from $35 to $40.

How the Intermediate PPO Works for You

Sandia Corporation provides insured participants with various medical plan choices. The Intermediate PPO is one of the medical plans offered. It includes preventive care, flexibility, and coverage nationally and internationally. The term "insured" as used in this document refers to a covered participant or any person who is enrolled in this Plan. The Intermediate PPO is administered by

United of Omaha. Your plan choices for accessing medical care are represented in the chart below.



*For an insured whose primary coverage is Medicare and whose physician does not accept Medicare assignments, the insured may be responsible for filing claim forms.

The in-network PPO option allows you to self-direct your care to any in-network physician or facility listed in your directory, subject to applicable precertification requirements. The out-of-network Non-PPO option allows you to self-direct your care to any licensed physician or facility that you choose. Some procedures are subject to applicable precertification requirements.

IMPORTANT **You can access either option at any time during the year, any time you need medical care.**

Section 2
Eligibility

This section outlines the service area for enrollment purposes as well as the eligibility requirements for active employees, retirees, other eligible persons, and dependents. It also provides information on coverage options when a Sandia employee/retiree is married to another Sandia employee/retiree, and information concerning a Qualified Medical Child Support Order (QMCSO).

Note—Active or retired employees who are insured in any of the other health plans offered by Sandia are not eligible to participate in this Plan. The option to choose participation in any Sandia plan is available during the Open Enrollment period held each fall.

Employees

You are eligible to enroll in this Plan the day you report for active employment if you are a:

- Regular, full- or part-time employee as classified by Sandia for payroll purposes
- Limited-term exempt or non-exempt employee
- Faculty sabbatical appointee **not** eligible for other group health care coverage
- Non-represented, year-round student interns who are enrolled in a post-secondary educational program and who are not covered by another medical plan

For purposes of coverage under this Plan, an individual is eligible only if:

- The individual satisfies all requirements for coverage under the Plan
- Sandia withholds required federal, state, or FICA taxes from his/her paycheck
- Sandia issues him/her a W-2 for the year in which a medical service under the Plan is provided
- Sandia issues the above W-2 no later than the year following the year in which the medical service was provided

EXCEPTIONS

1. **An employee receiving benefits under Sandia's Job Incurred Accident Disability Plan who does not have taxes withheld by Sandia from his/her paycheck, but who otherwise satisfies the eligibility requirements of this Plan, is an "employee" for purposes of coverage under this Plan.**
2. **An employee on inactive status because he/she is on a Sandia-approved leave of absence, as evidenced by the written approval then required for such leave, who otherwise satisfies the eligibility requirements of this Plan, is an "employee" for purposes of coverage under this Plan.**

You are also eligible to enroll in this Plan if you are a(n):

- Retired employee (if Medicare-eligible, it is strongly recommended that you enroll in Medicare Parts A and B to optimize your coverage [see Intermediate PPO and Medicare, page 9-1])
- Insured who, after January 1, 1982, became disabled before retirement and is eligible to receive Sandia long-term disability benefits

Employee Contributions

Employees who are members of the Intermediate PPO share in the monthly cost for coverage. An Intermediate PPO insured's monthly cost-sharing is based on a "buy up" approach from the Basic PPO and the insured's base salary. The premiums are structured on a 3-tier design using January 1 salary data.

EXCEPTION

Monthly costs for represented employees are outlined in their bargaining agreement.

The monthly cost-sharing amount is deducted from your bi-weekly paycheck in two equal installments each month.

Employees have the opportunity to enroll in the Pre-Tax Premium Plan to pay for these costs on a pre-tax basis upon initial enrollment or during the annual Open Enrollment (refer to the Pre-Tax Premium Plan Booklet).

Note—Part-time employees working 20 hours a week pay one-half the full premium cost.

Dual Sandians

If you are a Sandia employee married to another Sandia employee/retiree, you may elect to cover yourself as (1) an individual, (2) a dependent of your Sandia spouse, or (3) as the primary covered employee/retiree with your Sandia spouse as a dependent. Cost-sharing of monthly contributions is based on the salary tier of the primary Sandia insured. If you and your Sandia spouse elect to be covered separately, any eligible dependents may be covered under either spouse; i.e., some dependents may be enrolled under one spouse while other dependents are enrolled under the other spouse. No dependents may be covered under both Sandians simultaneously.

Under the Plan, employees/retirees or eligible dependents cannot be covered as both a primary insured and a dependent, or as a dependent of more than one primary insured.

Generally, your Plan benefits may not be assigned or alienated; however, an exception applies in the case of a Qualified Medical Child Support Order (QMCSO) (see Appendix D for definition).

Active or retired employees who are insured in the CIGNA POS, Top PPO, Basic PPO, or Kaiser HMO are **not** eligible to participate in this Plan. The election to participate in the Intermediate PPO is available once a year during Open Enrollment.

Retirees (Non-Medicare-Eligible)

Persons who retire and are non-Medicare-eligible will continue to use the Intermediate PPO as if they were active employees. The Intermediate PPO will be primary until they become Medicare-eligible.

Retirees (Medicare-Eligible)

You are Medicare-eligible if you are age 65 and not an active employee. (Please see Intermediate PPO and Medicare, page 9-1.)

Long-Term Disability Terminee (Medicare-Eligible)

If you have been receiving Social Security disability benefits for at least 24 months, you are Medicare-eligible. (Please see Intermediate PPO and Medicare, page 9-1.)

End Stage Renal Disease (Medicare-Eligible)

If you have this condition, you are Medicare-eligible. (Please see Intermediate PPO and Medicare, page 9-1.)

Eligible Dependents

Eligible dependents are those who are dependents of a primary insured and any child of an insured who is recognized as an alternate recipient in a QMCSO (see page 2-6). The Plan has two classes of dependents: Class I and Class II. Benefit provisions of this Plan generally apply to both Class I and Class II dependents. However, Behavioral Health coverage for Class II dependents **is not** available for services related to a diagnosis of substance abuse.

Class I Dependents

Tip

The Claims Administrator periodically may require continuing proof of eligibility.

If you are the primary insured under the Plan, your Class I dependents eligible for coverage include your:

- Spouse, not legally separated or divorced from you
- Unmarried child under age 19, including legally adopted children
- Unmarried child over age 19 but under age 24 who is "financially dependent" (see Appendix D) on you
- Unmarried child of any age who, because of physical or mental impairment,
  - is incapable of self-sustaining employment,
  - lives with you or in an institution or in a home that you provide, and
  - is financially dependent on you.

  United of Omaha determines if the applicant qualifies as a disabled dependent.

- Unmarried child who is recognized as an alternate recipient in a QMCSO (see Qualified Medical Child Support Order, page 2-6).

Class II Dependents

Your Class II dependents include your:

- Unmarried child who is not eligible as a Class I dependent
- Unmarried grandchild
- Unmarried brother or sister
- Parent or grandparent or your spouse's parent or grandparent

To qualify for coverage, a Class II dependent must:

- Be financially dependent on you
- Have a total income from all sources of less than $15,000/year other than the support you provide
- Have lived in your home, or one provided by you, in the United States for the most recent 6 months

Class II dependents for whom you currently pay a Class II premium are not counted as dependents in calculating the cost of the premium paid by Sandia. Class II dependents pay a separate premium share that differs according to the dependent's Medicare status.

Other Eligible Persons

You are also eligible if you are a(n):

- Employee on certain leaves of absence

  An employee on inactive status because he/she is on a Sandia Corporation approved leave of absence, as evidenced by the written approval required for such leave, who otherwise satisfies the eligibility requirements of this Plan, is a covered "employee" for purposes of coverage under this Plan.

- Surviving spouse of a regular employee or retiree
- Insured who elects and pays for temporary coverage (COBRA) and pays the appropriate premium when required (see Continuation and Conversions, page 11-1, for more information).

- Insured, who after January 1, 1982, became disabled before retirement and is eligible to receive Sandia long-term disability benefits. If you have been receiving Social Security disability benefits for at least 24 months, you are Medicare eligible (see page 9-2).
- Alternate payee/recipient through a Qualified Medical Child Support Order.

Qualified Medical Child Support Order

Generally, your Plan benefits may not be assigned or alienated. However, an exception applies in the case of any child of a participant (as defined by ERISA) who is recognized as an alternate recipient in a Qualified Medical Child Support Order (QMCSO). This Plan will comply with the terms of a QMCSO. A QMCSO is an order or judgment from a court or administrative body directing the Plan to cover a child of an insured under a group health plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected insured and each child (or the child's representative) covered by the order will be given notice of the receipt of the order. Coverage under the Plan pursuant to a QMCSO will not become effective until the Plan Administrator determines that the order is a QMCSO. QMCSOs will be reviewed by Sandia's Legal Division within 40 business days. If you have any questions, please contact the Sandia BCSC at 505-845-BENE (2363). You have the right to obtain a copy of the procedures governing QMCSOs at no charge.

Eligibility Appeal Procedures

If United of Omaha denies your claim or a dependent's claim **because of eligibility**, you may contact the Sandia BCSC at 505-845-BENE (2363) to request a review of eligibility status. A written notification will be sent to you within 3 business days of your request, informing you of your eligibility status. If you are not satisfied with this decision, you may request in writing that your eligibility status or your dependent's eligibility status be reviewed by the Employee Benefits Committee (EBC), which you must do within 180 days of the date of the letter informing you of your eligibility status. The EBC has the exclusive right to interpret insured eligibility thereunder. The secretary of the EBC has the authority to make the final determination for urgent care appeals. The determination of the EBC or its secretary is conclusive and binding. For appeal response timeframes, please see Appendix E. You must exhaust the appeal process before you seek any other legal recourse. Eligibility for incapacitated dependents is determined by United of Omaha. For appeals concerning incapacitated status, please follow the procedure on page 10-3.

Section 3

Enrollment & Disenrollment

This section outlines the enrollment procedures for new hires, reclassified employees (e.g., change in employee status such as Limited Term Employee to a regular employee), active employees, students, and retirees, as well as how to enroll and disenroll dependents. It also provides information on the option to waive/drop coverage altogether, the option of disenrolling and re-enrolling if you take a leave of absence under the Family and Medical Leave Act (FMLA). For the election change events that permit mid-year election changes, see the Pre-Tax Premium Plan Booklet for a definition.

New Hires/Reclassified Employees

As a new hire or reclassified employee newly eligible for medical coverage, you can elect to enroll yourself and your eligible dependents in the Intermediate PPO **within 31 calendar days of your date of hire or reclassification**. You will be given an enrollment form and payroll deduction card to complete.

To enroll:

- Complete the Medical Insurance Enrollment Form. Keep your copy as proof of coverage until you receive your Intermediate PPO ID card(s).
- Complete the payroll deduction card, making sure you indicate whether you want your premium to be deducted on a pre-tax or after-tax basis. Refer to the Pre-Tax Premium Plan Booklet.
- Mail the form and payroll deduction card to Sandia BCSC at MS 1022.

If you enroll in the Intermediate PPO within 31 calendar days, coverage will be retroactive to your date of hire or reclassification. If you do not enroll yourself and your eligible dependents within 31 calendar days of becoming a new hire or a reclassified employee newly eligible for medical coverage, you will be able to enroll yourself and your eligible dependents in the Basic PPO only, within six months of your new hire or reclassified date. Coverage will be retroactive to your date of eligibility. You will not be allowed to enroll yourself and your eligible dependents if there has been an intervening Open Enrollment period when you could have enrolled.

Note—If your effective coverage date is prior to the 16th of the month, you will be required to pay the applicable cost-share amount for the month in which you were hired or reclassified. If your effective coverage date is after the 15th of the month, you will not be required to pay the cost-share amount for the month in which you were hired or reclassified.

Note—If you terminate employment and are rehired within 30 days, you (and any covered dependents at the time of disenrollment) will automatically be reinstated into the Intermediate PPO. If you terminate employment and are rehired after 30 days, you may elect to be automatically reinstated to your prior election or you may make a new election.

Active Employees and Retirees

Eligible persons may elect to enroll in the Intermediate PPO once a year during the Open Enrollment period held each fall. If you enroll in the Intermediate PPO during Open Enrollment, coverage will be effective January 1 of the following calendar year. Employees and retirees may also enroll if they experience a loss of coverage during the year due to:

- **Loss of eligibility under another plan** – An eligible employee or retiree (and/or his/her dependents) who declined coverage when initially eligible because of having other medical coverage, and who later loses the other coverage, may apply for coverage for himself/herself and eligible dependents within 31 days of this event.
- **COBRA is exhausted after coverage under another plan** – An eligible employee or retiree (and/or his/her dependents) who has exhausted coverage under another plan outside Sandia, may apply for coverage for himself/herself and eligible dependents within 31 days of this event.
- **Employer contributions to other coverage end** – An eligible employee or retiree (and/or his/her dependents), for whom employer contributions to the other plan in which he/she is enrolled have ended, may apply for coverage for himself/herself and eligible dependents within 31 days of this event.

Enrolling Dependents

Enrolling Class I Dependents

As soon as you gain an eligible dependent, notify the Sandia BCSC at 505-845-BENE (2363) in New Mexico or 925-294-2254 in California. All Class I dependents **must be enrolled** with the Sandia BCSC within 31 days of their eligibility or birth or within 31 days of a "mid-year election change event" (see the Pre-Tax Premium Plan Booklet for a definition).

If you do not enroll your eligible dependent within 31 calendar days of a marriage, birth, adoption, placement for adoption, or obtaining guardianship, you will be able to enroll your eligible dependent in the Intermediate PPO within six months of the marriage, birth, adoption, placement for adoption, or obtaining guardianship, but you will have to pay an applicable premium-share on an after-tax basis. If the enrollment does not cause any change to your premium-share amount, for example, you are already paying for a family of three or more, you will be able to enroll the dependent at no additional cost to you. If you elect coverage under this option, you must remember to enroll your eligible dependent during Open Enrollment in order to have coverage in the subsequent year. Coverage for dependents gained as a result of marriage or legal guardianship will be effective on the date of enrollment and you will pay premiums from that day forward. Coverage for births, adoptions, or placements for adoption will be retroactive to the event and premiums will also be charged retroactively. You will not be allowed to enroll your eligible dependents if there has been an intervening Open Enrollment period when you could have enrolled them.

Coverage for an adopted child begins when the placement agreement and/or adoption papers are final. You must submit adoption papers to the BCSC. Medical expenses of the child before adoption, including the birth mother's prenatal, postnatal, and delivery charges, are not covered.

When enrolling your dependent, the following information must be provided:

- Dependent's name and relationship to you
- Date of birth
- Social Security number (not applicable to newborns)

IMPORTANT **Apply for this coverage as soon as your child becomes eligible. Conversely, you should disenroll your Class I dependent as soon as he/she becomes ineligible for coverage. Request enrollment and disenrollment forms from the Sandia BCSC. Ensure that the form is complete and return it to the Sandia BCSC.**

Coverage for Class II dependents is effective the first of the month following the date the enrollment form and payroll deduction card is received by the Sandia BCSC. Class II dependents **must be enrolled** with the Sandia BCSC within 31 days of meeting the Class II eligibility criteria, their birth, or a mid-year election change event (see the Pre-Tax Premium Plan Booklet).

Failure to enroll your Class II dependent within 31 days means that the Intermediate PPO **will not pay** for your dependent's medical care. In addition, you will have to wait until the next Open Enrollment period to enroll the dependent for coverage effective the following calendar year.

When enrolling your dependent, the following information must be provided:

- Dependent's name and relationship to you
- Date of birth
- Social Security number (not applicable to newborns)

Disenrolling Dependents

The following rules apply to retirees and to those employees who are having their medical premium deducted from their paychecks on an **after-tax basis**.

For rules regarding disenrolling dependents under the Pre-Tax Premium Plan (for employees only), refer to the Pre-Tax Premium Plan Booklet.

If you have a dependent who loses eligibility, please notify the Sandia BCSC as soon as the dependent loses eligibility. All Class I dependents must be disenrolled with the Sandia BCSC **within 31 calendar days** of the mid-year election change event causing ineligibility. The effective date of disenrollment will be the last day of the month in which the dependent becomes ineligible.

If you fail to disenroll your dependent within 31 days, upon notification to the Sandia BCSC at 505-845-BENE (2363), Sandia will

- Retroactively terminate coverage,
- Refund any applicable premium paid by you, and
- Consider disciplinary action for fraudulent use of the Plan.

If notification is not done in a timely manner, you could lose any rights to temporary continued coverage under COBRA.

You will be responsible for any claims incurred after your dependent loses eligibility and for reimbursement of any claims paid by the Intermediate PPO.

Note—You may also disenroll a dependent without a mid-year election change event if you are NOT enrolled in the Pre-Tax Premium Plan.

How to Disenroll a Dependent

To disenroll a dependent:

- Complete a Medical Insurance Dependent Disenrollment Form,
- Retain a copy for your files, and
- Mail the original to the Sandia BCSC at MS 1022.

Forms are available from the Sandia BCSC at 505-845-BENE (2363) or on the Web under Corporate Forms.

Sandia abides by a federal law referred to as the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1987 in which temporary continued coverage is provided to dependents who would otherwise lose group coverage due to specified events. Refer to Continuation and Conversions, page 11-1, for more information.

Waiving/Dropping Coverage in Sandia-Sponsored Medical Plans

If you are a surviving spouse and you waive or drop coverage, you can never re-enroll in a Sandia-sponsored medical plan.

You have the option to waive coverage for yourself and your dependents during the annual Open Enrollment period held each fall. If your premiums are deducted on an **after-tax basis**, you may also drop coverage for you and your dependents at any time during the year. If your premium is deducted on a **pre-tax basis**, you can drop coverage for you and your dependents outside of the Open Enrollment period held each fall **only if you experience a mid-year election change event**.

Coverage for any eligible dependent is based on your coverage as an employee; therefore, if you waive/drop coverage for yourself, you also waive/drop coverage for all of your covered and/or eligible dependents. Coverage will end on the last

day of the month in which you waive/drop coverage. If you waive/drop coverage, you will have the option to reinstate during the Open Enrollment period held each fall, with coverage becoming effective January 1 of the following calendar year.

Under the Health Insurance Portability and Accountability Act (HIPAA), if you waive/drop coverage for yourself and your covered dependents because of other health insurance coverage, and you and your covered dependents involuntarily lose eligibility for that coverage, you may be able to enroll yourself and your eligible dependents during the plan year, provided that you request enrollment within 31 calendar days after the other coverage ends. In addition, if you acquire a new eligible dependent as a result of marriage, birth, adoption, placement for adoption, or obtaining legal guardianship, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 31 calendar days after the marriage, birth, adoption, placement for adoption, or obtaining legal guardianship.

Employees enrolled in the Intermediate PPO have the **option** to cancel their coverage upon meeting the requirements of the FMLA. Written notification to cancel coverage must be received by the Sandia BCSC within 31 calendar days of the first day of absence. If you choose to cancel coverage, coverage will cease at the end of the month in which the BCSC receives written notification. If you do not cancel the coverage, coverage will be continued, and premiums will continue to be deducted (on a pre-tax or after-tax basis) during sickness absence, or made up upon return from an unpaid absence. If your absence is classified as a Leave of Absence other than FMLA, you will receive paperwork from the Sandia BCSC to continue paying your premiums monthly, on an after-tax basis. If you do not continue to pay premiums during a Leave of Absence, your coverage will be canceled.

If you do not cancel your coverage during sickness absence or an unpaid absence and you return in a subsequent calendar year, premiums not taken will be made up on an after-tax basis.

An employee can reenroll by notifying the Sandia BCSC in writing within 31 calendar days of returning to work. If notification to the Sandia BCSC to reinstate medical coverage for you and your eligible dependents is not received in writing within 31 calendar days of the date you return from the absence, you cannot reinstate medical coverage until the following calendar year, provided that the election is made during the next applicable Open Enrollment period.

Note—Members who voluntarily terminate Intermediate PPO coverage for themselves and their dependents while still employed with Sandia are not eligible for any COBRA continuation or individual conversion.

Election Change Events Allowing Mid-Year Election Changes

Certain events may permit changes to your health care coverage election at times other than during Open Enrollment so long as written notification is provided to the Sandia BCSC within 31 days of the election change event. Generally, the new election is effective on the **later** of the status change date or the date of written notification to the Sandia BCSC. In the case of a birth, adoption, or placement for adoption, the coverage will be retroactive to the event subject to enrollment rules. In the case of disenrollment due to ineligibility, the effective date will be the last day of the month in which the covered dependent became ineligible. In the case of disenrollment for any other reason, the effective date will be the last day of the month in which written notification was received by the Sandia BCSC or the status change date, whichever is later. Please see the Pre-Tax Premium Plan Booklet for more details.

This page intentionally left blank.

Section 4

Deductibles & Maximums

General Information

The following table summarizes the annual deductibles and out-of-pocket maximums, and lifetime maximums that apply to the in-network PPO option and the out-of-network non-PPO option. Only eligible covered expenses apply to the deductible. When accessing care in or out-of-network, the insured must first pay the annual deductible before the Plan begins to pay for covered health care services. When the insured meets the full deductible amount, the Plan begins to pay for eligible, covered expenses at the coinsurance amount of 80% in-network and 70% out-of-network.

Grid 1: General Information	In-Network Option PPO Option		Out-of-Network Option Non-PPO Option	
	Copayments[1] are the amount patient pays for services which are not subject to deductible. The coinsurance is the percent the plan pays (e.g., 80% of negotiated fees).		**Copayments[1] are the amount patient pays for services which are not subject to deductible.** The coinsurance (70%) is the percentage the plan pays subject to U&C after deductible has been met.	
Benefit				
Annual Deductible[2]	Individual	Family	Individual	Family 3 or more
	$250	$750	$500	$1,500
Medicare Primary[3]	$250	$500	$500	$1,000
Annual Out-of-Pocket Maximum[2]	Individual	Family	Individual	Family
	$1,000	$2,000	$2,000	$4,000
Medicare Primary[3]	$500	$1,000	$500	$1,000
Lifetime Maximum	None Infertility has a $30,000 lifetime max		None Infertility has a $30,000 lifetime max	
Medicare Primary	Medicare primary only $150,000 (see page 9-3) 1st $3500 does not apply to lifetime max		Medicare primary only $150,000 (see page 9-3) 1st $3500 does not apply to lifetime max	

Note: Precertification requirements are not applicable to Medicare primary members.

1 Copayments do not apply to deductibles. Copayments do apply to out-of-pocket maximums.

2 Does not transfer (cross-apply) between in-network and out-of-network.

3 Does transfer (cross-apply) between in-network and out-of-network

Non-Medicare-Eligible

Payments Not Applied to Deductible

Copayments, amounts above U&C charges, charges not covered by the Plan, prescription drug copays, and charges incurred because of failure to obtain required precertifications do not apply toward the deductible.

Family Deductible

Each family member may contribute toward the family deductible based on Plan usage. However, contribution maximums are limited to the individual deductible amount.

After three members in a family of three or more meet the individual deductible, the family deductible is satisfied. No more than the individual deductible amount will be applied to the family maximum per member.

Example: A family of five members has an in-network family deductible of $750 in-network. During the calendar year, the father and mother have each incurred in-network expenses of $1,000 and $2,000, respectively. The three children have incurred in-network expenses as follows: first child–$800, second child–$750, and third child–$750. These expenses are determined to be covered charges and are applied to the deductible and the out-of-pocket maximum for the in-network benefit. The Claims Administrator applies these covered charges in the order of receipt of the claims. The individuals contribute to the in-network deductible as follows:

Family In-Network Deductible Example			
	Expenses Incurred	**Individual Deductible**	**Allowable Contribution**
Father	$1,000	$250	$250
Mother	$2,000	$250	$250
1st Child	$800	$250	$250
2nd Child	$750	$0	$0
3rd Child	$750	$0	$0
		Total:	**$750**

After these charges are applied to the family deductible, no additional charges are applied to the deductible even though some members of the family have not met the individual deductible.

If the same family accesses out-of-network services, their deductible of $1,500 would be met as follows:

Family Out-of-Network Deductible Example			
	Expenses Incurred	**Individual Deductible**	**Allowable Contribution**
Father	$1,000	$500	$500
Mother	$2,000	$500	$500
1st Child	$800	$500	$500
2nd Child	$750	$0	$0
3rd Child	$750	$0	$0
		Total:	**$1,500**

Out-of-Pocket Maximum

When an insured using the in-network PPO option has incurred $1,000 of his/her eligible out-of-pocket cost for covered medical expenses, no additional copayments (or coinsurance when applicable) will be required for the remainder of the calendar year when using the in-network PPO option for that insured. When an insured is using the out-of-network non-PPO option and has incurred $2,000 of his/her eligible out-of-pocket costs, no additional copayments or coinsurance will be required for the rest of the calendar year for that insured. Or, when a family has incurred $2,000 of expenses by using in-network benefits, no additional copayments or coinsurance will be required for the rest of the calendar year when using in-network services. Or, when a family has incurred $4,000 of expenses by using out-of-network benefits, no additional copayments or coinsurance will be required for the rest of the calendar year when using out-of-network services. Eligible expenses include deductible, copayments, and coinsurance; they do not include amounts above U&C charges. When using the out-of-network non-PPO option, charges above U&C are the insured's responsibility even after the out-of-pocket maximum has been met. United of Omaha will accumulate the deductible, copays, and coinsurance paid and will notify insureds via Explanation of Benefits (EOB) when the out-of-pocket maximum is reached.

The out-of-pocket maximums in the in-network PPO and out-of-network non-PPO options do not cross-apply.

Out-of-Pocket Maximum		
	Individual Out-of-Pocket	**Family Out-of-Pocket[1]**
In-Network	$1,000	$2,000
Out-of-Network	$2,000	$4,000

EXAMPLE: In a calendar year, a family of four meets the in-network family $2,000 out-of-pocket maximum as follows:

Out-of-Pocket Maximum in-Network Example			
	Out-of-Pocket Expenses Out-of-Network	**Applied to Out-of-Pocket In-Network**	**Applied to Out-of-Pocket Out-of-Network**
Spouse	$2,500	$1,000	$0
1st Child	$500	$500	$0
2nd Child	$500	$500	$0
Total:	**$2,500**	**$2,000**	**$0**

For the remainder of the calendar year, any additional covered medical expenses submitted by any family member under the in-network PPO option will be paid at 100% of the negotiated fee. None of the above out-of-pocket, in-network expenses will be applied toward the out-of-network out-of-pocket maximum.

EXAMPLE: In a calendar year, a family of four meets the out-of-network family $4,000 out-of-pocket maximum as follows:

Out-of-Pocket Maximum Out-of-Network Example			
	Out-of-Pocket Expenses Out-of-Network	**Applied to Out-of-Pocket In-Network**	**Applied to Out-of-Pocket Out-of-Network**
Spouse	$2,000	$0	$2,000
1st Child	$1,000	$0	$1,000
2nd Child	$1,000	$0	$1,000
Total:	**$4,000**	**$0**	**$4,000**

If the same family accesses out-of-network providers and meets those out-of-pocket maximums, any additional out-of-network expenses will be covered at 100% of U&C charges. None of the out-of-pocket expenses will be applied to the in-network out-of-pocket maximum. The out-of-pocket maximums in the in-network PPO and out-of-network non-PPO options do not cross-apply.

[1] The family out-of-pocket maximum is two times the individual out-of-pocket maximum. The family maximum contribution per member is no more than the individual out-of-pocket amount.

IMPORTANT **The following payments do NOT apply to out-of-pocket maximums for either option:**

- **Expenses in the Prescription Drug Program**
- **Charges in excess of U&C fees**
- **Precertification penalties caused by failure to obtain precertification or late call**
- **Out-of-network charges in behavioral health benefits**
- **Expenses not covered by the Plan**

Infertility, Reproduction, and Family Planning

Reaching the Infertility Maximum of $30,000

When the covered participant reaches the $30,000 lifetime maximum benefit, no additional reimbursement for any Phase I procedures or for any Phase II procedures incurred to treat infertility are payable. Other covered Phase I procedures related to family planning or reproduction (excluding infertility) may be payable.

Medicare-Eligible

Payments Not Applied to Deductible

Copayments, amounts above U&C charges, charges not covered by the Plan, and prescription drug copayments do not apply toward the deductible.

Out-of-Pocket Maximum

When a Medicare-eligible retiree has incurred $500 of his/her eligible out-of-pocket costs for covered medical expenses in-network and/or out-of-network (excluding prescription drug expenses or charges above U&C), no additional copayments or coinsurance will be required from the insured for the remainder of the calendar year (excluding prescription drug copayments or charges above U&C). See page 8-4 through 8-7 for examples.

This page intentionally left blank.

Section 5

Coverages/Limitations

What the Intermediate PPO Covers

The Intermediate PPO provides a wide range of medical care services for you and your family. All coverage is based on medical necessity. Eligible employees, retirees, and others are eligible to enroll and participate in the Intermediate PPO. See Eligibility, page 1-1, for more information regarding who is eligible. The following series of grids details Plan coverages. The in-network PPO option requires you to obtain care from United of Omaha networks and the out-of-network Non-PPO option allows you to seek care from any licensed provider.

Grid 1: General Information	In-Network Option PPO Option		Out-of-Network Option Non-PPO Option	
	Copayments[1] are the amount patient pays for services which are not subject to deductible. The coinsurance is the percent the plan pays (e.g., 80% of negotiated fees).		**Copayments[1] are the amount patient pays for services which are not subject to deductible.** The coinsurance (70%) is the percentage the plan pays subject to U&C after deductible has been met.	
Benefit				
Annual Deductible[2]	Individual	Family	Individual	Family 3 or more
	$250	$750	$500	$1,500
Medicare Primary[3]	$250	$500	$500	$1,000
Annual Out-of-Pocket Maximum[2]	Individual	Family	Individual	Family
	$1,000	$2,000	$2,000	$4,000
Medicare Primary[3]	$500	$1,000	$500	$1,000
Lifetime Maximum	None Infertility has a $30,000 lifetime max.		None Infertility has a $30,000 lifetime max	
Medicare Primary	Medicare primary only $150,000 (see page 9-3) 1st $3500 does not apply to lifetime max		Medicare primary only $150,000 (see page 9-3) 1st $3500 does not apply to lifetime max	

Note: Precertification requirements are not applicable to Medicare primary members.

1 Copayments do not apply to deductibles. Copayments do not apply to out-of-pocket maximum.

2 Does not transfer (cross-apply) between in-network and out-of-network.

3 Does transfer (cross-apply) between in-network and out-of-network

Grid 2: Office Care, Lab, and Major Medical Services	In Network Option PPO Option	Out-of-Network Option Non-PPO Option
	Copayments are the amount patient pays for services which are not subject to deductible. The coinsurance is the percent the plan pays (e.g., 80% of negotiated fees), **after deductible has been met.**	The **coinsurance (70%)** is the amount the plan pays **subject to U&C after deductible.**
Benefit		
Office Care – Physician visits Includes PCP (In physician office only) Includes alternate opinions – Specialist	$15 copay per visit $25 copay per visit Office visit copay Includes: • Office visit • Consultation • Routine physical exams & preventive health care services • Ophthalmology exam (Non-refractive) • Hearing exam • Post-operative follow-up • Services after hours & emergency office visits • Allergy testing • Office surgery	70% of U&C 70% of U&C
Maternity – Newborn and Mothers Health Protection Act	Under federal law, mothers and their newborns who are covered under group health plans are guaranteed a stay in the hospital of not less than 48 hours following a normal delivery or not less than 96 hours following a cesarean section.	
– Physician's Care Initial visit	$15 copay per office visit if PCP or $25 if Specialist	70% of U&C
– Delivery, Prenatal & Post-natal care	80%	
– Hospital Inpatient Care	See Inpatient Care below	
• Delivery-including routine post-natal care.	80%	70% of U&C
• Nursery Care for Well-baby Newborn	80%	70% of U&C
Ambulance and Air Ambulance (only when ground transpor is not appropriate)	80%	70% of U&C
Emergency Room Care (See pages 6-12 to 6-13)	80%	70% of U&C
Urgent Care Facilities (See pages 6-12 to 6-13)	80%	70% of U&C

Note: Precertification requirements are not applicable to Medicare primary members.

GRID 2: Office Care, Lab, and Major Medical Services (continued)	In-Network Option PPO Option	Out-of-Network Option Non-PPO Option
	Copayments are the amount patient pays for services which are not subject to deductible. The coinsurance is the percent the plan pays (e.g., 80% of negotiated fees), **after deductible has been met.**	The **coinsurance (70%)** is the amount the plan pays **subject to U&C after deductible.**
Benefit		
Inpatient Care – Hospital Services – Surgeon – Physician Visit – Anesthesiologist	**Precertification Required**[1] 80%	**Precertification Required**[1] 70% of U&C
Outpatient Surgery - (Other than in physician's office). See page 6-3. – Facility fees – Professional fees – Ancillary services	**Precertification Required**[1] 80% 80% 80%	**Precertification Required**[1] 70% of U&C 70% of U&C 70% of U&C
Inpatient & Outpatient Lab and Radiology	80%	70% of U&C
MRI & Cat Scans	80%	70% of U&C
Organ Transplant (Experimental procedures are not covered) (See Medical Specialty Network [MSN] in SPD)	**Precertification Required**[1] 80%	**Precertification Required**[1] 70% of U&C
Preventive Care – Office visits, routine physical exam, well woman exam[2] – Prostate specific antigen (PSA), and other routine cancer screenings[2] – Immunizations, including those required for business and personal travel – Well-baby care	 $15 copay per PCP visit or $25 Specialist 80% 80% $15 copay per visit PCP or $25 Specialist	 70% of U&C 70% of U&C 70% of U&C 70% of U&C

Note: Clarification and notification of the following benefits are mandated by the Women's Health Act of 1998. If an insured has had a mastectomy, she may elect to have breast reconstruction. Coverage by this plan is provided for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas under the Intermediate PPO plan provisions.

Note: Precertification requirements are not applicable to Medicare primary members.

---

[1] Precertification non-compliance penalty is $300 (see pages 6-2 and 6-3 for procedures requiring precertification).

[2] As determined medically necessary by your physician.

Grid 3: Other Medical Services	In Network Option PPO Option	Out-of-Network Option Non-PPO Option
	Copayments are the amount patient pays for services which are not subject to deductible. The coinsurance is the percent the plan pays (e.g., 80% of negotiated fees), **after deductible has been met.**	The **coinsurance (70%)** is the amount the plan pays **subject to U&C after deductible.**
Benefit		
Durable Medical Equipment:	Refer to your Provider Directory or call United of Omaha Member Services for assistance in locating the vendor. **Precertification Required for DME and supplies over $1,000 for PPO and non-PPO**[1]	
— External prosthetics and appliances such as but not limited to wheelchairs, hospital beds, respiratory equipment — Oxygen (portable) — Apnea monitor — Bilirubin — AFO Brace — C-PAP	80%	70% of U&C
Supplies — Crutches — Splints — Trusses — Ostomy Supplies — Glucometer — Oxygen (except portable) — Oxygen Supplies	80%	70% of U&C
Prescription dispensed other than at pharmacy (i.e., physicians office)	80%	70% of U&C
Hearing Aids (Initial purchase and exam only when required due to injury or illness)	$25 copay per visit for exam by specialist or $15 copay PCP 80% for hearing aid	70% of U&C
Eye Exam for Non-refractive Care due to illness or injury to the eye	$15 copay per visit PCP or $25 specialist	70% of U&C
Eyeglasses/ Contact Lenses (Initial pair only when required due to the loss of a natural lens)	80%	70% of U&C
	Note: The Sandia Vision Care Plan is available to active employees and their dependents for routine refractive vision care.	

Note: Precertification requirements are not applicable to Medicare primary members.

[1] Precertification non-compliance penalty is $300 (see pages 6-2 and 6-3 for procedures requiring precertification).

Grid 4: Behavioral Health	In Network Option PPO Option	Out-of-Network Option Non-PPO Option
	Copayments are the amount patient pays for services which are not subject to deductible. The coinsurance is the percent the plan pays (e.g., 80% of negotiated fees), **after deductible has been met.**	The **coinsurance (50%)** is the amount the plan pays **subject to U&C after deductible.**
Benefit		
Behavioral Health (Mental Health & Substance Abuse Program Maximum of **60** inpatient days a year NOTE: Class II dependents are not eligible for substance abuse benefits	**Precertification Required**[1] (except initial visit) — Must use network provider and facility — Out of pocket maximum applicable — First initial screening visit per episode at $0 copay — Plan pays 80% of negotiated fees, after deductible has been met — Maximum of 20 outpatient visits per calendar year (PPO & Non-PPO Combined) — Two days of partial hospitalization are equivalent to one full day of inpatient hospitalization	**Precertification Required**[1] (except initial visit) — Use of non-network provider and facility — Out-of-pocket maximum not applicable — Plan pays 50% (after deductible) of U&C for inpatient and outpatient services — Maximum of 20 outpatient visits per calendar year (PPO & Non-PPO Combined) — Two days of Partial Hospitalization are equivalent to one full day of Inpatient Hospitalization
Employee Assistance Program (EAP)	**Precertification Required**[1] (except initial visit) — Up to eight (8) visits per year at $0 copay	Not available

Note: Precertification requirements are not applicable to Medicare primary members.

[1] Precertification non-compliance penalty is $300 (see pages 6-2 and 6-3 for procedures requiring precertification).

Grid 5: Treatments and Therapies	In-Network PPO Option	Out-of-Network Option Non-PPO Option
	Copayments are the amount patient pays for services which are not subject to deductible. The coinsurance is the percent the plan pays (e.g., 80% of negotiated fees), **after deductible has been met.**	The **coinsurance (70%)** is the amount the plan pays **subject to U&C after deductible.**
Benefit		
Skilled Nursing Facility	**Precertification Required**[1] 80% no limit	**Precertification Required**[1] 70% of U&C no limit
Home Health Care and Hospice Care **(Does not cover custodial care)**	**Precertification Required**[1] 80%	**Precertification Required**[1] 70% of U&C
Allergy Treatment – Serum – Office Visit – Testing – Shot Only	 80% $15 copay PCP or $25 specialist $15 copay PCP or $25 specialist 80%, no copay	 70% of U&C 70% of U&C 70% of U&C 70% of U&C
Speech Therapy (subject to limitations on the number of visits and demonstrated improvement as determined by United of Omaha)	Predetermination Recommended 80%	Predetermination Recommended 70% of U&C
Physical Therapy & Occupational Therapy (subject to limitations on the number of visits and demonstrated improvement as determined by United of Omaha)	Predetermination Recommended 80%	Predetermination Recommended 70% of U&C
Chiropractic Care & Acupuncture Therapy	80%	70% of U&C
Radiation Therapy Chemotherapy	80%	70% of U&C
Massage Therapy	Not covered	Not covered
Nicotine Addiction Biofeedback and hypnotherapy, limited to maximum lifetime benefit of 5 visits each	80% w/limits	70% of U&C w/limits

Note: Precertification requirements are not applicable to Medicare primary members.

[1] Precertification non-compliance penalty is $300 (see pages 6-2 and 6-3 for procedures requiring precertification).

Grid 6: Family Planning, Reproduction, and Infertility Treatments (see page 6-9 for additional information)	In-Network Option PPO Option	Out-of-Network Option Non-PPO Option
	Copayments are the amount patient pays for service s which are not subject to deductible. The coinsurance is the percent the plan pays (e.g., 80% of negotiated fees), **after deductible has been met.**	The **coinsurance (70%)** is the amount the plan pays **subject to U&C after deductible.**
Benefit		
Drug Therapy	Drug therapy is covered under the Prescription Drug Plan and does not apply toward the $30,000 maximum or to the deductibles in the Intermediate PPO unless implanted/injected in the physician's office and billed through the provider. If billed through the provider and reimbursed under the in-network or out-of-network option, the charges are applied to the $30,000 maximum. Only drugs consumed by a covered participant are covered.	
Family Planning	$15 copayment for PCP office $25 copayment for specialist office 80% if outpatient surgery	70% of U&C for allowable procedures
Infertility Maximum	A maximum lifetime benefit of $30,000 per person is allowed. This maximum is accumulated from any Infertility expenses paid following **a confirmed diagnosis of infertility.** There are limitations to eligible procedures. To obtain additional information and predetermination of benefits, call United of Omaha member services at 1-800-488-0167.	
Phase I Treatments Include (but are not limited to): — Diagnostic testing for infertility — Reversals of prior sterilizations — Medically necessary ultrasounds — Laparoscopies	Benefits are considered same as any other sickness (e.g., for diagnostic testing for infertility, refer to lab work coverage)	Benefits are considered same as any other sickness
Phase II Treatments Include (but are not limited to) — Artificial insemination — Gamete intrafallopian transfers — Embryo transplantation — Limited donor expenses for egg donor — Storing and preserving embryos for up to two years	Benefits are considered same as any other sickness. (Call United of Omaha for information on specific services.)	Benefits are considered same as any other sickness

Note: Precertification requirements are not applicable to Medicare primary members.

This page intentionally left blank.

Section 6

Accessing Care

In this section, you will find out how to access care under the in-network and out-of-network options. A description of non-emergency and non-urgent care, as well as how to access care during emergencies and urgently needed care, is provided for medical and behavioral health conditions and for the Employee Assistance Program. This section will also describe the United of Omaha provider networks and how you may obtain the latest provider directory electronically or on hard copy.

In-Network PPO Option

The in-network PPO option provides you access to physicians, facilities, and suppliers who are contracted with United of Omaha to provide their services at negotiated fees. This results in lower out-of-pocket costs to you. When you use the in-network option of the Intermediate PPO, all services and supplies covered must be acquired from in-network providers or suppliers, be medically necessary, and be an eligible covered expense under this plan. Please refer to Coverages, page 5-1, for coverage details. Some procedures may require precertification, which you are responsible for asking your physician to obtain from United of Omaha (see page 6-3). For the most updated in-network provider listings in your area, please contact United of Omaha Customer Service at 1-800-488-0167, or you may access their Web site at www.mutualofomaha.com.

The advantages of using the in-network PPO option include:

- Lower deductibles
- Lower out-of-pocket maximums
- Reasonable copayments or lower coinsurance
- No responsibility for amounts exceeding U&C charges
- Generally, no claims to file

Out-of-Network Non-PPO Option

This option offers a lower level of benefit but enables the insured to self-direct to licensed providers outside the Plan network. Out-of-pocket costs will be higher.

The insured is responsible for deductibles, coinsurance, and amounts exceeding U&C charges. The insured is also responsible for filing all claims and obtain precertification for all hospital care and certain medical procedures in order to be eligible for benefits. After satisfying the required deductible, the insured is reimbursed to 70% of the U&C charge as determined by United of Omaha, for medical coverages (see Coverages, page 5-1) and 50% of U&C for Behavioral Health (see Coverages, page 5-5).

Out-of-Area Coverage

Insured participants who live in an area where United of Omaha does not have a contracted network will be covered at the in-network level of coverage.

Precertification

If a service or procedure does not require precertification, it does not mean it is covered. In order to ensure that services and procedures are covered, please obtain a predetermination (see page 6-4).

Precertification is the process by which United of Omaha evaluates whether covered benefits are medically necessary and whether the treatment or procedure is deemed experimental (see page D-6 for a definition).

To receive maximum benefits in the in-network PPO option, the provider must obtain precertification for certain benefits (see page 6-3). It is the insured's responsibility to check with the provider to ensure that this requirement is met. When accessing the out-of-network non-PPO option, the insured is required to obtain precertification for certain plan benefits (see page 6-3), unless Medicare or another plan is primary. If precertification is not obtained when required, and the Intermediate PPO is your primary plan, a $300 penalty will apply. This means that the first $300 of the claim will not be paid.

If your primary care physician and United of Omaha's Customer Service do not agree in advance for the need of services or treatment, the insured can appeal the decision by asking that the Medical Director at United of Omaha review the situation. Appeal procedures are listed on page 10-2. Regardless of the decision and/or recommendation of United of Omaha's Customer Service, or what the plan will pay, it is always up to the insured and the doctor to decide what, if any, care he/she receives. Customer Service at United of Omaha does not provide medical advice.

Precertification is obtained from United of Omaha. For precertification, call United of Omaha Customer Service at 1-800-488-0167.

The following services require precertification to receive the highest level of in-network and out-of-network benefits **unless** you are Medicare-primary or have another plan as primary:

- Hospital stay (inpatient) — 7 days in advance. Emergency hospitalization — call within 2 working days after admission to meet this requirement

> **Note—For expenses incurred for hospital confinements for which review does occur but for which inpatient care is not certified as medically necessary:**
>
> - **Benefits for hospital room and board will not be payable; and**
> - **Expenses for other covered hospital services will be considered in accordance with policy provisions**

- Surgical procedures (inpatient or outpatient) — 7 days in advance. Emergency surgery — call within 2 working days of procedure for precertification.
- Outpatient surgical procedures requiring precertification:
  - Carpal tunnel release
  - Cochlear implants
  - Endometrial ablations
  - Hysterectomy
  - Knee arthroscopy
  - Pelvic laparoscopy
  - Tonsillectomy with/without adenoidectomy
  - Tympanostomy tube insertion
  - UPP (uvulopalatopharyngoplast) or laparoscope aided UPP

Additional benefits requiring precertification are:

- Durable medical equipment and supplies over $1,000
- Skilled nursing
- Home health care
- Hospice
- Transplants
- EAP (except for initial visit)

- Behavioral Health—precertification has to be obtained whether accessing the in-network PPO option or the out-of-network non-PPO option, except for the first visit.

The first $300 of covered charges will not be reimbursed if you or a family member do not obtain required precertifications from United of Omaha, or fail to notify United of Omaha within the required time frame, for hospitalizations, surgeries, and other procedures listed as requiring precertification.

EXCEPTION

Insured participants who have primary coverage under a non-Sandia group health care plan (to include Medicare) are not required to call in advance.

Predetermination of Benefits

The Intermediate PPO covers a wide range of medical care treatments and procedures. However, medical treatments that are investigational, experimental, or not proven to be medically effective are not covered by the Core Plan. Contact United of Omaha before incurring charges that may not be covered.

In addition, some services may be covered only under certain circumstances (see Exclusions, page 7-1) and may be limited in scope, such as but not limited to speech therapy, occupational therapy, temporomandibular joint (TMJ) syndrome, infertility, procedures that may have a cosmetic effect, and physical therapy. Predetermination of benefits is recommended to help you determine your out-of-pocket expense. Also, some benefits require precertification; therefore, it is important that you call United of Omaha for information on covered services.

Case Management

The Comprehensive Case Management Program is a program that, as early as possible, identifies patients who have the potential for having high-cost medical expenses, may require extensive hospitalization, or have complicated discharge planning needs. The program identifies these patients so that coordination of services and cost-effective alternative care arrangements can be made. Referral to Case Management screening takes place when:

- Two or more admissions within 3 months for the same or a related problem
- Two or more emergency or urgent care visits within 3 months for the same or related problem

- A hospital stay of more than 10 days
- Over $50,000 in claims year to date for the same or related condition

Case Management also takes place for the following conditions:

- Cancer
- Cerebrovascular accident (CVA)
- Chronic respiratory disease
- Congenital heart disease
- Diabetes
- Immune system deficiencies
- Infectious disease
- Ischemic heart disease
- Neonatal complications
- Neurodegenerative disorders (including multiple sclerosis, muscular dystrophy, amyotrophic laterial sclerosis)
- Organ transplant
- High risk pregnancies
- Spinal cord injuries
- Trauma

Special care arrangements, as determined by the case manager, are coordinated with the physician.

Case management is a voluntary, confidential, and private process and may involve some or all of the following activities:

- Establishing goals and a care plan with the physician, insured, and/or family that may include on-site visits
- Assessing ongoing treatment at a hospital, rehabilitation center, nursing home, hospice, or insured's home
- Investigating alternative facilities and services
- Establishing home health care treatment, if appropriate
- Planning for discharges

The intent of case management is to ensure that medically necessary and appropriate services are provided to the insured. The evaluation process used in case management may reduce medically unnecessary, inappropriate, and/or harmful services, and manage costs in some cases. For more information, call United of Omaha at 1-800-468-0167 (or see page F-1 for contact information).

Behavioral Health Program

Your Behavioral Health Program and the network of behavioral health care specialists are managed by United of Omaha. The Intermediate PPO allows both in-network and out-of-network benefits. **Using your in-network benefit allows you to receive the maximum available benefit.**

Note—To access behavioral health benefits, you may call United of Omaha Customer Service at 1-800-488-0167 to verify that the provider you have chosen is in the network.

You may select providers either in-network or out-of-network. In either case, **you must have precertification** from United of Omaha to access behavioral health services after the first visit. Precertification is not required for your first appointment. If you have scheduled a second visit, make sure your behavioral health care practitioner has called United of Omaha Customer Service for precertification of treatment before your second visit. You will incur a $300 penalty if precertification to seek services from the billing provider is not on file, whether the provider is in-network or out-of-network.

If you select an in-network behavioral health care practitioner, he or she must call United of Omaha Customer Service at 1-800-488-0167 to initiate the Medical Necessity Review process. If the provider does not obtain precertification, a $300 penalty will apply.

If you select an out-of-network practitioner, it is YOUR RESPONSIBILITY to call or have the practitioner call United of Omaha Customer Service at 1-800-488-0167 to initiate the Medical Necessity Review process.

The following chart summarizes the benefits and limitations; additional details follow within this section.

United of Omaha—Behavioral Health Program	
In-Network PPO Option	**Out-of-Network Non-PPO Option**
■ Prior authorization from United of Omaha required except for initial visit ■ Out-of-pocket maximum applicable ■ Must use United of Omaha network provider or facility ■ Initial screening visit ($0 copay) ■ Plan pays 80% of negotiated fees (after the deductible) for inpatient and outpatient services ■ Annual visit maximum: 20 visits, in-network and out-of-network combined ■ Inpatient days limit: 60 days per calendar year	■ Prior authorization from United of Omaha required except for initial visit ■ Out-of-pocket maximum not applicable ■ Use of non-United of Omaha network provider or facility ■ Plan pays 50% of U&C fees (after deductible) for inpatient and outpatient services ■ Annual visit maximum: 20 visits, in-network and out-of-network combined ■ Annual inpatient day limit: 60 days per calendar year

In-Network PPO Option

You may access inpatient and/or outpatient behavioral health care services through self-selection of a contracted behavioral health care specialist or hospital identified in your provider directory or by calling United of Omaha Customer Service at 1-800-488-0167. If you have questions concerning the selection of an in-network behavioral health care specialist, assistance is also available by calling the same number.

Out-of-Network Non-PPO Option

Accessing out-of-network services means that you have selected a behavioral health care specialist or hospital outside the United of Omaha provider network. **Selecting an out-of-network specialist or hospital reduces your available benefit.**

Maximum Available Benefit

Whether using your in-network or out-of-network benefit, in order to qualify for the maximum available benefit for the option you choose, your benefit plan requires precertification and a **Medical Necessity Review** of the treatment services. The Medical Necessity Review determines if the services you plan to obtain will meet your needs and are medically necessary under the terms of your benefit plan. The Medical Necessity Review is conducted by United of Omaha and the behavioral health care practitioner you have selected.

You have a maximum of 20 out-patient visits per calendar year and an in-patient confinement limit of 60 days per calendar year.

Emergency Treatment

In the case of inpatient and/or emergency services, the behavioral health care practitioner, the emergency service, a friend, or family member must notify United of Omaha within two working days of admission or as soon as reasonably possible. If inpatient or emergency services occur after business hours, holidays, or a weekend, voice message is available, and a call will be returned the next business day.

If the hospital is not in the network, in-network benefits will be paid until the patient is stabilized. Once stabilized, the patient must be moved to a network hospital to continue in-network benefits. The patient may elect to remain in the out-of-network hospital and receive out-of-network benefits, as long as the treatment is confirmed to be medically necessary by United of Omaha.

Employee Assistance Program

Sandia offers Intermediate PPO insureds the counseling services of an Employee Assistance Program (EAP). The EAP counseling services are designed to provide assessment, referral, and follow-up to employees experiencing some impairment from personal concerns including, but not limited to, health, marital, family, financial, substance abuse, legal, emotional, stress, or other personal concerns that may adversely affect day-to-day activity.

Accessing EAP Services

You are offered two access points to receive EAP counseling:

- You may obtain EAP counseling by contacting a designated in-network EAP affiliate as identified in your provider directory. If you would like assistance with identifying an in-network EAP counselor, you may contact your Sandia EAP office or you may contact United of Omaha at 1-800-488-0167.
- You may also obtain EAP counseling by contacting your Sandia EAP office. The Sandia EAP is administered by Sandia Medical Services and is not a part of the Intermediate PPO. For on-site EAP services in Albuquerque, call 505-845-8085. In Livermore, call 925-294-2200.

EAP Benefits and Precertification Requirements

Your EAP benefit allows up to eight visits annually to off-site in-network EAP providers at $0 copay. It is important to note that except for the initial visit, the in-network EAP affiliate you select is responsible for calling United of Omaha at 1-800-488-0167 to receive authorization for additional visits beyond your initial EAP assessment visit.

On-Site EAP Services

The Sandia EAP provides information regarding education and training programs at the worksite that focus on mental health issues such as substance abuse, family and marital concerns, stress, and healthy lifestyle development. The Sandia EAP also assists employees and managers in resolving work-related issues that might affect job productivity.

For further information, call the following numbers:

New Mexico:	505-845-8085
California:	925-294-2200

Confidentiality

EAP counseling services are confidential within the limitations imposed by state and federal law and regulations. When an insured visits an EAP counselor for the first time, confidentiality is described in more detail.

Infertility, Reproduction, and Family Planning

In general, medical care related to infertility, reproduction, and family planning is covered under the Intermediate PPO and includes a full range of procedures. The Intermediate PPO categorizes the covered charges under procedures for infertility, reproduction, and family planning into Phase I or Phase II covered charges.

A maximum lifetime benefit of $30,000 per person is allowed for infertility treatments. This maximum is accumulated from any Phase I expenses paid following a confirmed diagnosis of infertility and for any resultant Phase II treatment expenses covered by the Plan. There are limitations to eligible procedures. To obtain additional information and predetermination of benefits, call United of Omaha Customer Service at 1-800-488-0167.

Phase I Treatments

Phase I procedures include but are not limited to the following types of treatments:

- Testing and diagnosis of infertility
- Sterilization procedures such as vasectomies and tubal ligations
- Medically necessary ultrasounds and laparoscopies
- Treatments required due to a medical diagnosis such as endometriosis
- Family planning devices that are implanted or injected by the physician such as intrauterine devices (IUDs), Norplants, or Depo-provera
- Reversals of prior sterilizations

Intermediate PPO insureds can obtain these benefits under the in-network PPO and out-of-network Non-PPO options. Depending on the provider chosen, covered charges are reimbursed at the appropriate level after deductible and coinsurance.

Testing and treatments after a confirmation of a diagnosis of infertility are applied to the $30,000 lifetime maximum.

Phase II Treatments

Phase II treatments are covered **only** with a confirmed diagnosis of infertility. Phase II expenses, plus Phase I expenses paid subsequent to a confirmed diagnosis of infertility, are applied to a per person lifetime maximum of $30,000. Phase II procedures include but are not limited to the following types of treatments:

- Artificial insemination
- Gamete intrafallopian transfers (GIFT)
- Embryo transplantation
- Laparoscopies for egg retrieval
- Purchase of sperm, if billed separately
- Limited donor expenses for egg donor. (Only the same charges that would be eligible to extract the egg from a covered employee are allowed for the donor. Also, prescription medications taken by a donor are not allowable charges.)
- Storing and preserving embryos for up to two years

Approved charges for these services are reimbursed under the in-network PPO option if using a network provider or under the out-of-network Non-PPO option if using an out-of-network provider.

IMPORTANT **Phase II expenses incurred without a diagnosis of infertility will not be reimbursed.**

Prescription Drugs for Phase I and Phase II Treatments

Prescription drugs related to infertility, reproduction, and family planning are covered under the Prescription Drug Program. Prescription drugs obtained through the Prescription Drug Program and used for infertility treatment may require a diagnosis of infertility. The cost of these drugs is not applied to the $30,000 infertility maximum.

EXCEPTION

If the prescription drug or device is provided by the physician and billed through the provider's office or facility charges, the charge will be reviewed by the Plan Administrator for reimbursement. If categorized as a Phase II treatment, the charges will be applied to the $30,000 maximum. These charges may also be applied to the appropriate Plan deductibles and out-of-pocket maximums. Prescriptions for a donor are not covered by either the Prescription Drug Program or the Intermediate PPO.

Precertification

Precertification is not required for obtaining some infertility benefits, nor for some diagnostic testing. **However, a predetermination is recommended** to ensure that the proposed services will be eligible for reimbursement. In addition, the precertification requirements that are required under these options for specific procedures still apply (e.g., hospital admissions; surgical procedures including elective surgeries; inpatient/outpatient, emergency hospitalizations; and maternity and birth notifications in the event that infertility treatments are successful).

Emergency Care and Urgently Needed Care

Emergency care and urgently needed care coverage through the Intermediate PPO is very specific, **so please read this section carefully**. Be sure you know what steps to take when a nonoccupational medical emergency arises.

Definition and Examples of Medical Emergency

A medical emergency is an accidental injury or the sudden and unexpected onset of a condition requiring immediate medical or surgical care. Certain conditions are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Other conditions are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or the sudden inability to breathe. There are many other acute conditions that United of Omaha may determine are medical emergencies. All of these emergencies require quick action.

Reimbursement for emergency care will not be denied if, in good faith and with average knowledge of health and medicine, you seek emergency care for an illness that you believe is an acute condition that requires immediate medical attention. United of Omaha will take the following factors into consideration in determining if the illness or condition is reimbursable as emergency care:

- A reasonable person's belief that the circumstances required immediate medical care that could not wait until the next working day or next available appointment
- The time of day the care was provided
- The presenting symptoms
- Any circumstances that prevented the insured from seeking emergency care under established Intermediate PPO guidelines

Emergencies Occurring Within the Service Area

If you have an emergency, go to the nearest hospital emergency room. These facilities are open 24 hours a day, 7 days a week.

If you are hospitalized in nonparticipating facilities and would like to be transferred to the nearest participating hospital, you will be transferred when medically feasible with any ground ambulance charges covered in full. If you decline to be transferred, coverage will be provided under the out-of-network benefit level.

Emergencies Occurring Outside the Service Area

If you have an emergency, go to the nearest hospital emergency room. These facilities are open 24 hours a day, 7 days a week.

The Intermediate PPO will pay at the in-network benefit level for treatment of sudden, unexpected, and acute illnesses or injuries you receive from out-of-area providers in the case of a medical emergency. Expenses for health care services that you should have received before leaving the service area or that could have been postponed safely until your return are eligible for coverage at the out-of-network benefit level.

Definition and Examples of Urgent Care

Urgent care is defined as care provided for medical events that are not life-threatening but require prompt medical attention. Examples of urgent situations include sprains, strains, vomiting, cramps, diarrhea, bumps, bruises, colds, fevers, small lacerations, minor burns, severe stomach pains, swollen glands, rashes, poison ivy, and back pain.

Urgently Needed Care Occurring Inside the Service Area

When an urgent illness or injury occurs, you may access any in-network urgent care facility to receive care. You will be responsible for the copayment at the time of service. If you receive care:

- In a participating urgent care facility, you are covered at 80% after deductible has been met
- In a participating emergency room, you are also covered at 80% after deductible has been met

If you go to a **nonparticipating** physician or an urgent care facility, you will be reimbursed at 70% of U&C.

Tip

For information on in-network urgent care facilities in your area, call United of Omaha at 1-800-488-0167.

Urgently Needed Care Occurring Outside of the Service Area

When an urgent illness or injury occurs and there are no in-network facilities available, your claim will be processed at the in-network benefit level for the initial visit. Follow-up visits will be covered at the out-of-network level of benefit.

Non-Emergency or Non-Urgent Care When You're Away from Home

United of Omaha has contracted with providers in more than 90 metropolitan areas. If you are not experiencing an emergency or urgent situation, please call United of Omaha to obtain information on in-network providers in the area. If you access an out-of-network provider or facility even if there are no in-network providers, your claim will be processed at the out-of-network benefit level (for emergencies, see page 6-13).

Provider Networks

If your physician is interested in becoming a member of any of these networks, please call 1-800-488-0167.

Network availability is dependent on the ability of the administrator to contract with provider networks. United of Omaha has contracted with networks across the country. You may access in-network PPO providers in most areas nationwide.

Sandia through United of Omaha strives to make available to you quality health care services by way of United of Omaha's provider credentialling processes. However, the networks are contracted by United of Omaha and even though Sandia strives to provide you with quality medical services, neither Sandia nor its plans can guarantee quality of care. Employees always have the choice of what services they receive and who provides their healthcare regardless of what the plan covers or pays.

In the Greater Albuquerque area, the providers, specialty care physicians, hospitals, and other health care providers/facilities participating in the network are affiliated with Presbyterian or University Hospitals. In some cases, United of Omaha has established direct contracts with other providers. The participating providers work with United of Omaha to organize an effective and efficient health care delivery system. Outside the greater Albuquerque area, United of Omaha has contracted with providers offering in-network PPO care.

In California, the providers, specialty care physicians, hospitals, and other health care providers/facilities participating in the network are affiliated with the CCN Network. CCN works with United of Omaha to organize an effective and efficient health care delivery system. In some cases, United of Omaha has established direct contracts with other providers.

In other areas, United of Omaha contracts with provider networks all over the United States. If a provider networks is not available within 50 miles of your residence, your claims will be paid at the in-network level of benefit as long as you access a licensed provider for covered expenses.

Medical Specialty Network

In 1993, United of Omaha developed a Medical Specialty Network (MSN) with facilities that provide services for tissue and organ transplants. This network is designed to give insureds an opportunity to access providers that demonstrate quality medical care to transplant patients. Under the MSN, the following transplant types are included:

- Kidney
- Lung
- Kidney/pancreas
- Bone marrow/peripheral blood stem cell
- Heart
- Liver
- Heart/lung

The facilities in the MSN are chosen for the quality of their entire transplant program and are evaluated against defined, measurable performance indicators and clinical outcomes that include the following:

- Age of transplant program and volume of transplants since inception
- Volume of transplants performed yearly
- Experience and tenure of the transplant team
- Experience of their lead surgical team
- Outcomes as measured by survival rates, graft survival rates, re-transplant rates, complications, and length of stay
- United Network of Sharing (UNOS) membership
- Medicare certification
- Geographic location and fixed-fee arrangements

Use of the MSN enables our insureds access to transplant facilities that have demonstrated above-average outcomes and below-average complication rates. Each facility is evaluated annually by a United of Omaha Companies' medical panel to ensure that the quality and outcome criteria continue to be met. The MSN has 15 transplant facilities. For more information, please contact 1-800-488-0167.

Provider Directories

The United of Omaha Nationwide Provider Directories list providers and auxiliary services available in-network. You can select your physician from family care physicians, internists, pediatricians, and other specialists who have contracted to participate in this network. Specialty care and hospital services gener-

ally are provided by the hospital with which the physicians and specialists you select are affiliated.

Provider directories will be furnished from United of Omaha or can be obtained online as described below. Directories are current as of the date printed. The provider networks change often. For the most current information, see below or call United of Omaha at 1-800-488-0167.

Online Directories-on-Demand

Available at www.mutualofomaha.com, Directories-on-Demand are medical provider directories that you create at your desk. You can get an electronic, up-to-date, customized directory at any time.

It is easy and only takes a few minutes. All that is needed is access to the Internet:

- Log on to www.mutualofomaha.com.
- Select Health/Dental Provider Directories from the Home page or from the Group Benefit Services page.
- Choose Directories-on-Demand.
- The Web site will walk you through the rest.

Select the Directory That Meets Your Needs

- Complete directory—covers a specific geographic area, similar to the traditional paper directories, but because the data are updated monthly, there are no addenda to worry about.
- City/state directory—create a directory by the city you choose. It can include all, or specific, provider types and specialties.
- Address-based directory—specific to geographic parameters you select. This directory can also include all, or specific, provider types and specialties.

If you do not have Web access, you may obtain a hardcopy of the provider directory for your area by calling United of Omaha at 1-800-488-0167.

When You Schedule An Appointment

When you call the provider's office to make an appointment, identify yourself as a Sandia Intermediate PPO insured. When you check in for your appointment, use your Intermediate PPO identification card to identify yourself as a Sandia Intermediate PPO insured and to pay the appropriate copayment.

Canceling Your Appointment—If you cannot keep your appointment, please be courteous to other insureds and to your providers by calling to cancel your appointment. The time you leave open can be used by someone else. Any charge for missed appointments will not be covered by the Plan.

Transferring Your Medical Records—If you want previous medical records transferred to your physician's office, ask the office receptionist for instructions. You may also ask your former physician to transfer your records.

Tip

1. Failure to present the ID card may result in incorrect billing and claim payment delay.

2. Obtain receipts for copayments at the time of the visit if you are claiming your copayments against the Sandia Health Care Spending Account.

When You Change Your Address

When you move, you should change your address in the Sandia database. If you are an active employee, change your address through your Center secretary or from your Benefits home page. If you are a retiree, or cash-paying member (COBRA and surviving spouses), notify the Sandia BCSC at 505-845-BENE (2363) of your address change. For California, call 925-294-2254. If you relocate, your PPO network could change. For provider information, you may access United of Omaha for the most updated provider information.

If you move into **California** and wish to enroll in the Kaiser HMO, you must contact the Sandia BCSC within 31 days at 925-294-2254.

This page intentionally left blank.

Section 7

Exclusions

What the Intermediate PPO Does Not Cover

Although the Intermediate PPO provides benefits for a wide range of medically necessary services, there are specific conditions or circumstances for which the Intermediate PPO will not provide benefit payments. In general, the Plan will not pay for any expense that is primarily for the insured's convenience or comfort or that of the insured's family, caretaker, physician, or other medical provider.

General Medical Plan Exclusions

You should be aware of these exclusions[1] that include but are not limited to items in the following table.

Exclusions	Examples
Administrative fees, penalties, and limits	■ Charges that exceed what United of Omaha determines are U&C fees (out-of-network option only) ■ Insurance filing fees, attorney fees, physician charges for information released to Claims Administrator, and other service charges and finance or interest charges ■ Amount you pay for failure to contact United of Omaha for precertification including unauthorized visits (applies to in-network and out-of-network options) ■ Behavioral health services when you do not obtain precertification from United of Omaha[1]
Cosmetic surgery	■ Removal of breast implants without documented leakage of silicon ■ Breast reduction/augmentation **except** after breast cancer (see page 5-3)[2] and/or if medically necessary, **and except for the following:** 1. For injuries; 2. For repair of defects that result from surgery for which the insured was paid benefits under the policy; or 3. For the reconstructive (not cosmetic) repair of a congenital defect that materially corrects a bodily malfunction. **Note:** For the purposes of this exclusion, poor self-image or emotional or psychological distress do not constitute a bodily malfunction.
Dental procedures	Dental procedures are not covered under this Plan **except** for injuries to sound, natural teeth, the jaw bone, or surrounding tissue. Treatment must be initiated within 12 months of injury. Jaw joint disorders (TMJ) and orthognathic surgery are covered only if medically necessary and require precertification.

[1] For Behavioral Health Program exclusions, see page 7-3; for infertility, reproduction, and family planning exclusions, see page 7-5.

[2] There are no limits on number of prostheses and no time limitations from date of the mastectomy.

Exclusions	Examples
Drugs	Outpatient drugs are covered under the Prescription Drug Program (see Appendix A) **except** drugs dispensed, administered, and billed through the provider or facility that is approved by United of Omaha for coverage, and all intravenously administered medications.
Equipment	■ Exercise equipment (e.g., exercycles, weights, etc.) ■ Hearing aids for hearing loss (see benefit under "hearing aids," page 5-4, for illness and injury coverage) ■ Braces prescribed to prevent injuries while you are participating in athletic activities ■ Household items, including but not limited to – air cleaners and/or humidifiers – bathing apparatus – scales or calorie counters – blood pressure kits – water beds ■ Personal items, including but not limited to – support hose, except medically necessary surgical stockings – foam cushions – pajamas ■ Items payable under the Prescription Drug Program (see Appendix A)
Experimental or investigative treatment	Experimental or investigative drugs, devices, medical treatments or procedures, and any related services
Hospital fees	■ Expenses incurred in any federal hospital, unless the insured is legally obligated to pay ■ Hospital room and board charges in excess of the semi-private room rate unless medically necessary and approved by United of Omaha ■ In-hospital personal charges (e.g., telephone, barber, TV service, toothbrushes, slippers)
Miscellaneous	■ Transportation, **except** ambulance and air ambulance – to the nearest hospital – for movement between hospitals when medically necessary to a facility in the area of the member's permanent residence, or for approved participation in the MSN program (see page 6-15) ■ Eye exams or eye refractions, **except** as stated on page 5-4. ■ Eyeglasses or contact lenses prescribed, **except** as specified on page 5-4. Contact lenses are not considered a prosthetic device. ■ Eye surgery and laser procedures when primary purpose is to correct visual acuity ■ Treatment or services – incurred when the patient was not an insured – for illness or injury resulting from the insured's intentional acts of aggression, including armed aggression, except for injuries inflicted on an innocent bystander (e.g., you did not start the act of aggression) – for job-incurred injury or illness for which payments are payable under any Workers' Compensation Act, Occupational Disease Law, or similar law – that are reimbursable through any public program other than Medicare or through no-fault automobile insurance ■ Charges in connection with surgical procedures for sex changes ■ Charges for blood or blood plasma that is replaced by or for the patient
Not medically necessary	Treatments or services determined not to be medically necessary by the Claims Administrator (see "medically necessary service" in Appendix D)
Old claims	Claims received 12 months after date when charges were incurred

Exclusions	Examples
Services, supplies, therapy, or treatments	Charges that are: ■ custodial in nature ■ otherwise free of charge to the insured ■ from a person who lives with you or is part of your or your spouse's immediate family ■ furnished under an alternative medical plan provided by Sandia ■ for "developmental care" (see Appendix D) after an optimal level of improvement has been reached ■ for maintenance care ■ for massage therapy ■ for educational therapy when not medically necessary ■ for educational testing ■ for family therapy, including marriage counseling and bereavement counseling. Family therapy and bereavement counseling are covered for employees and their dependents only through the Employee Assistance Program (call United of Omaha at 1-800-488-0167 or Sandia on-site EAP at 505-845-8085 in NM and 925-294-2200 in CA). ■ for smoking-cessation programs, **except** as stated on page 5-6, Nicotine Addiction
Surgical and nonsurgical treatment for obesity	■ Surgical operations for the correction of morbid obesity determined by United of Omaha not to be medically necessary to preserve the life or health of the insured ■ Treatment for appetite control, food addictions, or eating disorders that are not documented cases of bulimia or anorexia meeting standard diagnostic criteria as determined by the Plan

Behavioral Health Program Exclusions

The Intermediate PPO will not cover mental health services for the following conditions, diagnoses, or therapies:

- Conduct disturbances unless related to a coexisting condition or diagnosis otherwise covered;
- Educational, vocational, and/or recreational services as outpatient procedures;
- Biofeedback for treatment of diagnosed medical conditions;
- Treatment for learning disabilities and pervasive developmental disorders other than diagnostic evaluation;
- Treatment that is determined by United of Omaha participating provider for mental health or United of Omaha medical director to be for the insured's personal growth or enrichment; or
- Court-ordered placements when such orders are inconsistent with the recommendations for treatment of United of Omaha participating provider for

mental health, the primary care physician, or United of Omaha's medical director.

- Services to treat conditions that are identified by the most current edition of the Diagnostic and Statistical Manual of Mental Disorders as not being attributable to a mental disorder
- Sex transformations
- Any services or supplies that are not medically necessary
- Custodial care
- Developmental care
- Treatment for caffeine or tobacco additions, withdrawal, or dependence
- Aversion therapies
- Treatment for codependency
- Non-abstinence-based or nutritionally-based treatment for substance abuse
- Services, supplies, or treatments that are covered for benefits under the medical part of this Plan
- Treatment or consultations provided via telephone, except if used for transition of care or interim care for a maximum of 8 weeks
- Services, treatments, or supplies provided as a result of any Worker's Compensation law or similar legislation, or obtained through, or required by, any government agency or program, whether federal, state, or any subdivision thereof, or caused by the conduct or omission of a third party for which the insured has a claim for damages or relief, unless the insured provides United of Omaha with a lien against such claim for damages or relief in a form and manner satisfactory to United of Omaha
- Conditions resulting from insurrection
- Any treatment related to sexual dysfunction
- Mental or nervous disorders that are classified as sexual deviations or disorders
- Services or supplies that
  - are considered experimental or investigational drugs, devices, treatments, or procedures; or
  - result from or relate to the application of such experimental or investigational drugs, devices, treatments, or procedures.
- Services or supplies that are primarily for the insured's education, training, or development of skills needed to cope with an injury or sickness

Infertility, Reproduction, and Family Planning Exclusions

The following procedures are not covered services:

- Purchase of eggs
- Services related to or provided to anonymous donors
- Storing and preserving sperm
- Donor expenses related to donating eggs/sperm except for egg retrieval expenses (including prescription drugs) except as stated on page 6-10
- Expenses incurred by surrogate mothers
- Sex change operations
- Over-the-counter medications for birth control/prevention

This page intentionally left blank.

Section 8

Coordination of Benefits

This section defines and explains Plan provisions designed to eliminate duplicate payments and provide the sequence in which coverage will apply (primary and secondary) when a person is covered under two plans.

Policy

All benefits under this Plan are subject to coordination with the benefits of other health care plans including Medicare if they are considered covered expenses under this Plan. Covered expense means any expense that is covered by at least one Plan during a claim period; however, any expense that is not payable by the primary plan because of the insured's failure to comply with cost containment requirements (e.g., second surgical opinions, pre-admission testing, pre-admission review of hospital confinement, mandatory outpatient surgery, etc.) will not be considered a covered expense and therefore is not paid under this Plan. (For information regarding Medicare coordination, see page 8-3 and examples on pages 8-4 through 8-7. For other information regarding Intermediate PPO and Medicare, see page 9-1.)

Rules for Determining Which Plan is Primary and Other Details of the Benefit Payment

The rules of the National Association of Insurance Commissioners (NAIC) for the Coordination of Benefits (COB) state that COB:

- Applies only to group plans, **not** to individual insurance
- Does **not** apply when married persons are both members in Sandia's plans
- Follows the birthday rule (see item 3 in the table on the following page)

Use the table on the following page to determine:

- If your plan is primary
- Which plan pays the benefit for employees, spouses, and dependents

	If...	then...
1	the other plan (including HMOs) does not have a COB provision,	the plan with no COB provision is primary.
2	both plans have COB provisions,	the plan covering the person as an employee is primary and will pay benefits up to the limits of that plan. The plan covering the person as a dependent is secondary and pays the remaining costs to the extent of coverage.
3	both plans have COB provisions and use the birthday rule for dependent children coverage,	the plan covering the parent whose birthday comes first (month and day) in the year is the primary plan and will pay benefits first. The plan covering the other parent is secondary and pays the remaining costs to the extent of coverage.
4	both plans have COB but do not use the birthday rule,	the male-female rule applies. The rule says that the father's group insurance is the primary plan and will pay the benefits first. The mother's group insurance is secondary and pays the remaining costs to the extent of her coverage.
5	both plans have COB but one parent is covered by the male-female rule and the other by the birthday rule,	the male-female rule applies. The rule says that the father's group insurance is the primary plan and will pay the benefits first. The mother's group insurance is secondary and pays the remaining costs to the extent of her coverage.
6	a divorce or legal decree establishes financial responsibility for health care for the dependent,	the parent who has that responsibility will be the holder of the primary plan.
7	a divorce decree does not establish financial responsibility for health care of the dependent,	the plan of the parent with custody is the primary plan. The other parent's plan is secondary.
8	a divorce decree does not establish financial responsibility and assigns joint custody,	each parent is primary when the child is living in that parent's home.
9	a divorce decree does not establish financial responsibility, and the parent with custody remarries,	the custodial parent's plan remains primary; the stepparent's plan is secondary. The noncustodial parent's plan is third.
10	payment responsibilities are still undetermined,	the plan that has covered the patient for the longest time is the primary plan.

Coordination of Benefits With Medicare

Sandia interfaces with Medicare to eliminate duplicate payments and provide a sequence in which coverage applies—generally, Medicare as primary and the Intermediate PPO as secondary—when an insured is covered under two contracts (in this case, Medicare and the Intermediate PPO). The following table presents a number of scenarios on how the sequence of coverage applies.

If you . . .	**then . . .**		
continue to work as an employee at Sandia after age 65 and do not enroll in Medicare,	Intermediate PPO is primary		
retire from Sandia and enroll for benefits at your new job and do not enroll in Medicare,	Your new coverage is primary	Intermediate PPO is secondary	
retire from Sandia, enroll for benefits at your new job, are over age 65, and enroll in Medicare,	Your new coverage is primary	Medicare is secondary	Intermediate PPO pays last
are age 65 and are the enrolled dependent of an employee who continues to work at Sandia after age 65 and you enrolled in Medicare,	Intermediate PPO is primary	Medicare is secondary	Any other coverage you may have pays last
are age 65 and are the enrolled dependent of an employee who works somewhere other than Sandia after age 65 and you enrolled in Medicare,	Spouse's plan is primary	Medicare is secondary	Any other coverage you may have pays last
(or your covered spouse or dependent) are age 65 or over or have been receiving Social Security disability benefits for at least 24 months, and you are eligible for Medicare,	Medicare is primary	Intermediate PPO is secondary	
have permanent kidney failure and are not covered by another employer's plan as an employee or dependent, and you are eligible for Medicare,	Medicare is primary	Intermediate PPO is secondary	
are under age 65, have been receiving disability benefits for at least 24 months, are a dependent of a working spouse, and you are eligible for and enrolled in Medicare,	Spouse's plan is primary	Medicare is secondary	Intermediate PPO pays last

When the Intermediate PPO becomes your secondary plan and you file your claims:

- Claims are filed first (primary) to Medicare by you or your physician.
- After Medicare considers the claim and responds with an EOB, you or your physician file the claim with United of Omaha for Intermediate PPO benefits whether you received the medical services in the in-network PPO option, the out-of-network Non-PPO option, or under out-of-area coverage.

- No claim filing is necessary if you use the in-network PPO option and your physician accepts Medicare assignment or agrees to file.

Coordination of benefits is required by the Intermediate PPO when Medicare coverage is primary even if you have chosen not to enroll with Medicare—except for the special situations, noted on page 9-2.

Examples of Coordinations of Benefits With Medicare

Office Visit Specialist In-Network Provider*

Total Charge: $210	Medicare Deductible	Balance after Deductible	Medicare Pays @80% after Deductible	Balance Due
Medicare	$100	$110	$88	$122

Total Charge: $210	Balance after Medicare	Minus Copay (OOP)	United Pays	SNL Retiree Pays
United of Omaha	$122	$25	$97	$25

*This example assumes the healthcare provider accepts Medicare assignment.

1st Claim of Year – Office Visit Specialist In-Network Provider

- Amount applied to Medicare deductible = $100.
- Amount applied toward out-of-pocket maximum (OOP Max) = $25.
- Specialist copay = $25.

Emergency Room In-Network Hospital*

Total Charge: $600	Medicare Pays @80%	Balance Due 20%
Medicare	$480	$120

Total Charge: $600	Balance after Medicare	United's In-network Deductible is $250 then 80%	United Would Have Paid	Medicare Paid $480 United Actually Pays	SNL Retiree Pays
United of Omaha	$120	$600 total charge minus $250 deductible = $350 payable at 80%	$280	$0	$120

* This example assumes the healthcare provider accepts Medicare assignment.

2nd Claim of Year – Emergency Room In-Network Hospital

- Medicare deductible has been met.
- Amount applied toward OOP Max for this claim = $320. The deductible of $250 + the 20% of $70 = $320.
- Total amount applied toward OOP Max year to date = $345. Balance to meet OOP Max = $155.
- In-network deductible = $250. OOP Max = $500.
- Medicare paid more than United of Omaha would have paid so United of Omaha pays $0.

Surgical Charge In-Network Outpatient Facility*

Total Charge: $800	Medicare Pays @80%	Balance Due 20%
Medicare	$640	$160

Total Charge: $800	Balance after Medicare	Balance Left to Meet Out-of-Pocket	United Pays	SNL Retiree Pays
United of Omaha	$160	$155	$5	$155

* This example assumes the healthcare provider accepts Medicare assignment.

3rd Claim of Year – Surgical Change In-Network Outpatient Facility

- United of Omaha subtracts the balance of the OOP Max from Medicare's balance.
- The retiree's OOP Max has been met.
- United of Omaha will reimburse the balance after Medicare, less amounts over usual and customary charges, on covered expenses for the remainder of the calendar year.
- The in-network deductible was met through a previous claim, therefore, the charges are considered at 80%.

Radiology Visit Out-of-Network Provider*

Total Approved Charge: $200	Deductible	Balance after Deductible	Medicare Pays @80% after Deductible	Balance Due %20
Medicare	$100	$100	$80	$120

Total Approved Charge: $200	Balance after Medicare	Deductible/ OOP Max	United Pays	SNL Retiree Pays
United of Omaha	$120	$200**	$0	$120

* This example assumes the healthcare provider accepts Medicare assignment.

** Maximum out-of-pocket is $500; United of Omaha deductible is $500.

1st Claim of Year – Radiology Visit Out-of-Network Provider

- Amount applied to Medicare deductible = $100.
- United of Omaha applies $200 radiology charge toward $500 deductible **and** toward OOP Max.
- OOP Max = $500.
- Balance of $300 remains to meet OOP Max and United of Omaha deductible.

MRI Out-of-Network Hospital*

Total Approved Charge: $1500	Medicare Pays @80%	Balance Due 20%
Medicare	$1200	$300

Total Approved Charge: $1500	Balance after Medicare	Deductible/ OOP Max Amount Remaining	United Pays	SNL Retiree Pays
United of Omaha	$300	$300	$0	$300

* This example assumes the healthcare provider accepts Medicare assignment.

2nd Claim of Year – MRI Out-of-Network Hospital

- Medicare deductible has been met.
- Amount applied toward OOP Max and United of Omaha deductible = $300.
- The OOP Max and United of Omaha deductible have been met for the calendar year.
- United of Omaha will reimburse the balance after Medicare less amounts over U&C charges on covered expenses for the remainder of the calendar year.

Behavioral Health Program Coordination With Other Plans

If you are eligible for similar benefits under other plans, your benefits will be coordinated. In addition, if your primary coverage is under another plan and this program provides secondary coverage, you must still follow the rules of this program to receive secondary benefits.

Subrogation and Reimbursement Rights

Subrogation means the Plan's or Claims Administrator's right to recover any Intermediate PPO payments made because of sickness or injury to you or your dependent when the sickness or injury was caused by a third party's wrongful act or negligence and for which you or your dependent have a right of action or later recover said payments from the third party.

If you or your dependent requires medical treatment because of a third party's wrongful act or negligence, the Intermediate PPO Claims Administrator, United of Omaha, will authorize payment of Plan benefits pursuant to the terms of the Plan. As a Plan participant, you and your dependents acknowledge and agree as follows:

- The Plan and/or Claims Administrator is subrogated to any recovery or right of action against that third party;
- You and/or your dependent will not take any action that would prejudice the Plan's subrogation rights (will not impede the Plan's recovery actions);
- You and/or your dependent will cooperate in doing what is reasonably necessary to assist in any recovery, including seeking recovery of medical expenses as an element of damages in any action you bring as a result of the

activity resulting in the sickness or injury (will assist the Plan to directly or indirectly recover payments);

- You and/or your dependent shall reimburse the Claims Administrator from any money recovered from the third party for any injury or treatment therefore or condition for which the Claims Administrator provided benefit; and
- The Claims Administrator may recover payments only to the extent that Plan benefits paid for treatment provided as a result of the injury or condition giving rise to the claim.

Sandia will be subrogated only to the extent of Plan benefits paid for that injury.

Note—If the injured party is a minor dependent, the primary member must perform the above agreements/duties.

Failure to comply with the Plan's subrogation rules may result in termination of coverage for cause (see page 11-2), as well as legal action by the Plan to recover benefits paid that would otherwise have been subject to recovery under the Plan's reimbursement/subrogation rights.

Section 9
Intermediate PPO and Medicare

What Is Medicare?

Medicare (Title XVIII) is administered by the Social Security Administration. Medicare is the U.S. federal government plan for paying certain hospital and medical expenses for individuals who qualify—primarily those over age 65. Benefits are provided regardless of income level. Medicare is government subsidized and government operated.

Medicare Part A (Hospital Insurance Plan) covers:

- Hospital benefits
- Hospice care
- Home health services
- Skilled nursing facility care (does not include nursing homes)

Persons age 65 or over who have enough quarters of coverage to receive Social Security, whether retired or still working (and such persons' spouses age 65 or over), receive Part A coverage at no cost. If the person remains employed and elects to continue in the employer's plan, Medicare is the secondary payer until such person retires.

If you are not eligible for free Medicare Part A coverage, you may enroll by paying the full premium. Enrollment in Medicare Parts A and B is strongly recommended to optimize your plan benefit. For purposes of coverage under this plan, you will be considered as if you were enrolled in Medicare Parts A and B. If you are Medicare-eligible, have chosen not to enroll in Medicare, and are not an active employee, the Intermediate PPO will pay claims as though you were enrolled, as secondary coverage.

Disabled persons who have been receiving Social Security Disability Benefits for at least 24 months and people with permanent kidney failure are also Medicare-eligible and can enroll in Part A at no cost.

Medicare Part B (Medical Insurance Plan) covers a portion of the following types of charges after an annual deductible is met:

- Physician

- Medical services
- Outpatient diagnostic or treatment services

Persons eligible for Medicare Part A can purchase Part B by paying a monthly premium. The payment is normally deducted from the Social Security benefit.

"Medicare-Primary" and "Medicare-Eligible" Statuses

In this Summary Plan Description, the terms "Medicare-eligible" and "Medicare-primary" are frequently used. **Medicare-eligible** means that a member has turned age 65 or has been receiving Social Security disability benefits for two years or has end stage renal disease. Eligibility is independent of whether you continue to work, when you begin to draw Social Security benefits, or whether you enroll for Medicare benefits.

In the Intermediate PPO, **Medicare-primary** status means that you are Medicare-eligible, not an active employee, not covered as a dependent of an active employee, are enrolled in Medicare, and pay premiums as applicable for Medicare Parts A and B coverage. Medicare-primary also means that when medical claims are filed, the claims are filed first (primary) to Medicare, and then, after consideration by Medicare, claims are filed (secondary) to the Intermediate PPO (see Coordination of Benefits, page 8-3). Class II dependents who are Medicare-eligible are always Medicare-primary, even if covered under an active employee.

If you do not elect coverage during your initial notification from Social Security to enroll, you continue to be eligible for Medicare and may enroll during subsequent appropriate enrollment periods. If you enroll for Medicare coverage on a timely basis, the penalties for late enrollment are not applicable. Contact your local Social Security office for complete details. If you choose not to enroll in Medicare even though you are eligible, the Intermediate PPO will reimburse payment on claims as though you were enrolled in Medicare.

Special Situations

In certain situations, the employer's health plan may continue to be the primary plan even though you are eligible for Medicare. The two exceptions that exist are as follows:

1. If you are Medicare-eligible, you do not enroll in Medicare, you continue to work at Sandia, and you are enrolled in the Intermediate PPO, then the Intermediate PPO is primary.

2. If you are Medicare-eligible, your spouse continues to work at Sandia, and your spouse enrolls you in the Intermediate PPO as a dependent, you continue to be Medicare-eligible, but your spouse's Intermediate PPO is primary.

When you elect to retire (situation 1 above is no longer applicable) or your spouse retires (situation 2 above is no longer applicable), you should enroll for Medicare coverage if you have not already done so. In both instances, Medicare then becomes the primary health insurer upon your or your spouse's retirement, and the Intermediate PPO becomes secondary for health care claim filing and coordination of benefits. If you have not enrolled in Medicare, your Intermediate PPO benefits will be reduced. The Intermediate PPO will pay claims as though you are enrolled in Medicare.

The Intermediate PPO is always secondary to Medicare unless you are covered as an active Sandia employee or as a dependent of an active Sandia employee.

Intermediate PPO for Medicare-Primary Members

The following are Intermediate PPO features or requirements when Medicare is your primary plan.

1. As of January 1, 2003, you will be required to pay copayments and be subject to deductible and out-of-pocket maximums as listed under the coverage grids (see pages 5-1 through 5-7).
2. If eligible, and not an active employee or dependent of an active employee, it is strongly recommended that you enroll in Medicare Parts A and B in order to maximize your claim reimbursements. The Intermediate PPO is your secondary plan if you meet the above criteria **whether you choose to enroll in Medicare Parts A and B or not**. Medicare Part A is Hospital Insurance and Part B is the Medical Insurance Plan. Part B of Medicare requires that you enroll and pay a premium for medical coverage.
3. Once the Intermediate PPO begins to pay as your secondary plan, you are subject to a lifetime maximum. The **maximum lifetime allowable** reimbursement for services paid for Medicare-primary insureds is $150,000. This lifetime maximum applies to in-network and out-of-network claims combined. The first $3,500 of benefits paid during each calendar year **do not apply** to the $150,000 maximum when accumulating paid claims during a calendar year. Only the amounts paid by United of Omaha after Medicare will be applied toward the lifetime maximum. All lifetime maximum accumulations recorded by prior Claims Administrators are considered and have been transferred to United of Omaha.

4. Copayments paid under the Prescription Drug Program **are not** applied to the deductible or the lifetime maximum in either option. These copayments are not coordinated with Medicare.

Medicare and Medicare HMOs

Enrollment in a Medicare HMO does not change your participation and eligibility in the Intermediate PPO. If you are eligible for Medicare coverage and you want to participate in the Intermediate PPO, you **must be** enrolled in Medicare Parts A and B (see Intermediate PPO and Medicare, page 9-1) in order to maximize your plan benefit. Failure to enroll in Parts A and B will result in reduced benefits. If you are eligible for **primary** Medicare coverage (Parts A and B), the Intermediate PPO is your **secondary** plan.

Medicare and Non-Sandia-Sponsored Medicare HMOs

Enrollment in a non-Sandia-sponsored Medicare HMO does **not** change your status in this Plan or your eligibility to be an insured. If you are eligible for primary Medicare coverage, this Plan is **secondary** regardless of whether you are:

- Covered directly by Medicare
- Enrolled in a non-Sandia-sponsored Medicare HMO

The Intermediate PPO does NOT pay for:

- Medicare premiums
- Enrollment fees or monthly premiums to a non-Sandia-sponsored Medicare HMO
- Any amount above insured's U&C charges

The following table summarizes coverage for Medicare and non-Sandia-sponsored Medicare HMOs.

If you . . .	then you . . .
are eligible for primary Medicare coverage and fail to enroll in Medicare Parts A and B, even if you must pay for Part A,	will lose benefits that would have been payable by Medicare on a primary basis. The Intermediate PPO will estimate what Medicare would have paid and will pay **only** the appropriate secondary portion.
enroll in a non-Sandia-sponsored Medicare HMO,	may have to pay a premium directly to the HMO, and you must continue to pay your Medicare Part B premium. If you continue to be enrolled in the Intermediate PPO, it will be second or third payer of benefits.
are enrolled in a non-Sandia-sponsored Medicare HMO and you do not abide by the Medicare HMO rules but instead obtain services outside the HMO,	will lose benefits that would have been payable by Medicare or the HMO on a primary basis, **and**, Intermediate PPO will estimate what Medicare would have paid and will pay covered charges **only** on a secondary basis.
are eligible for primary Medicare and fail to purchase Part B,	will lose benefits because the Intermediate PPO will estimate what Medicare would have paid and will pay **only** the appropriate secondary allowable portion.
secure services from a physician who chooses to opt out of Medicare,	will lose benefits that would have been payable by Medicare on a primary basis. The Intermediate PPO will estimate what Medicare would have paid and will pay **only** the appropriate allowable secondary portion.

Specific Rules for Medicare HMOs

You must follow the rules specific to each non-Sandia-sponsored Medicare HMO to receive the maximum benefits. An HMO will not pay for any health care services not affiliated with the HMO, except on rare occasions.

Physicians and Medicare Assignment

Assignment is an arrangement whereby some physicians agree to accept the Medicare-approved (allowable) amount as full payment for services covered under Medicare Part B. Medicare usually reimburses 80% of the allowable assigned fee directly to the physician, and the physician then bills the patient (or United of Omaha) for the remainder up to but not over the approved amount.

However, if your doctor does not accept Medicare assignment, this means that the physician has not agreed to accept the Medicare-approved amount as full payment.

If your doctor does not accept assignment, you are responsible for payment, and the physician may bill you for the full amount of his or her charges. And, because Medicare pays its share of the bill to you and not to the doctor when a claim is unassigned, the doctor could ask you to pay at the time of your visit.

You should discuss assignment issues with your doctor to determine your up-front out-of-pocket expenses. Even if your doctor does not accept Medicare assignment, your doctor is required to file with Medicare, and Medicare will pay you directly. Medicare will also file your claim with United of Omaha, attaching the Medicare EOB. United of Omaha will then reimburse you the difference between the Medicare share and the United of Omaha negotiated fee if you are using the in-network PPO option.

If using the out-of-network Non-PPO option, you will be reimbursed the difference between the Medicare share and the United of Omaha U&C charges for your geographic area if you have met the applicable deductibles. Any amount billed above the U&C charges is your responsibility.

If you choose to seek medical care from a physician, hospital, or supplier that is a non-Medicare approved provider, United of Omaha will estimate Medicare's benefit and leave you responsible for what Medicare would have paid.

Section 10

Claims and Appeals

Filing medical care claims for reimbursement is generally required only under the out-of-network Non-PPO option. Most providers in the in-network PPO option will file claims for you. Please check with your providers to verify that they will submit your claims.

Obtaining Reimbursement

To obtain reimbursement for medical care, attach the itemized medical bill to the claim form and mail it to the address shown on the claim form or the address on your Intermediate PPO ID card (see Appendix F for how to obtain claim forms). Itemized medical bills should include:

- Patient's full name
- Date and place of treatment or purchase
- Diagnosis
- Type of service provided
- Amount charged
- Name and address of provider and tax identification number, if available
- If other insurance is primary, the EOB (from the primary insurer) attached to your claim form

For prescription drugs purchased at out-of-network pharmacies, file your claims following the instructions outlined in Appendix A, Prescription Drug Program.

Note—See Obtaining Claim Forms/Envelopes, Appendix F.

Tip

This Plan has a 12-month filing limit from the date medical expenses are incurred to the date received at United of Omaha. We recommend that claims be submitted as soon as possible after the medical expenses are incurred. If you need assistance in filing a claim, call United of Omaha Customer Service at 1-800-488-0167.

Benefits Payments

Plan benefits are paid to the primary covered insured on behalf of the covered insured and his/her dependents as soon as possible after receipt of written proof of claim. For response timeframes from the Claims Administrator, please see Appendix B.

Note—The person who received the service is ultimately responsible for payment of services received from the providers.

If any benefits of the plan shall be payable to the estate of a participant or to a minor or individual who is incompetent to give a valid release, the plan may pay such benefits to any relative or other person either whom the plan determines to have accepted competent responsibility for the care of such individual or otherwise required by law. Any payment made by the plan in good faith pursuant to this provision shall fully discharge the plan and the company to the extent of such payment.

Participants cannot assign, pledge, borrow against, or otherwise promise any benefit payable under the plan before receipt of that benefit. Interest in the plan is not subject to the claims of creditors. Exceptions include:

- A Qualified Medical Child Support Order that requires a health plan to provide benefits to the insured's child.
- Subject to the written direction of an insured, all or a portion of benefits provided by the plan may, at the option of the plan and unless the individual requests otherwise in writing, be paid directly to the person rendering such service. Any payment made by the plan in good faith pursuant to this provision shall fully discharge the plan and the company to the extent of such payment.

Recovery of Excess Payment

The Claims Administrator has the right at any time to recover any amount paid by this plan for covered charges in excess of the amount that should have been paid under plan provisions. Payments may be recovered from covered insureds, providers of service, and other medical care plans.

By accepting benefits under this plan, the covered insured agrees to reimburse payments made in error and cooperate in the recovery of excess payments.

Claim Denials and Appeals

Sandia is committed to capturing, as error-free as possible, the information you provide us. United of Omaha uses this information to review and process your claims as quickly and accurately as possible. Please see Appendix B for the types of clams and timeframes for response from the Claims Administrator.

If United of Omaha denies your (or a dependent's) claim because of eligibility, see page 2-6.

If you dispute a denial by United of Omaha of your claim based on Plan coverage or you want to challenge a benefit determination, you have the right to request that United of Omaha reconsider its decision. The procedure for appealing to United of Omaha is outlined below.

If you have a claim denied because of . . .	then . . .
coverage eligibility (except for disability determinations)	contact the Sandia BCSC, 505-845-BENE (2363)
benefits administration or any other reason	contact United of Omaha, 1-800-488-0167

Filing an Appeal

United of Omaha has established procedures for hearing, researching, recording, and resolving any appeals or complaints an insured may have. The appeal procedure is limited to insureds and to former insureds seeking to resolve a dispute that arose during coverage. Additionally, an appeal **must be filed in writing** in order to be processed.

The written appeal must be sent to:

United of Omaha
Woodward Health Care Service Center
Attn: Sandia Unit
PO Box 9
Woodward, OK 73801

Review Processes

The following steps can be used to resolve any written appeal United of Omaha receives.

Step 1: First Level of Appeal

- If possible, United of Omaha's Administrative Services Department will resolve the complaint informally through review of previous medical information received, physician office records, and additional medical information requested from the physicians.
- If necessary, the complaint is referred to United of Omaha's Administrative Services Director or to United of Omaha's Medical Director for medical re-

view. Treatment may be reviewed by another physician with the same specialty.

For response timeframes from the Claims Administrator, please see Appendix B.

Step 2: Second Level of Appeal

- If the informal administrative review process does not resolve the complaint to the insured's satisfaction, the insured may request that the appeal be reconsidered by United of Omaha's Corporate PPO Committee.
- This request must be sent to United of Omaha's Administrative Service Department within 180 days of United of Omaha's notifying the insured of the previous appeal findings. This request should be sent to the address on the previous page. For response timeframes from the Claims Administrator, please see Appendix B.

You must exhaust the appeal process before you request an external review or seek any other legal recourse.

External Review

If you are not fully satisfied with the decision following completion of the second level appeal process and your claim was denied based upon lack of medical necessity or the experimental nature of the treatment, and if your claim was above $1,000, you may request that your claim be reviewed by an external independent review organization. The independent review organization is composed of persons who are not employed by United of Omaha or any of its affiliates. There is no charge for you to initiate this independent review process. United of Omaha will abide by the decision of the independent review. Administrative eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process. To request a review, you must write to United of Omaha at the address on page 10-3 within 180 days of your receipt of the second level appeal review denial. You may provide additional information to be considered. United of Omaha will acknowledge receipt of your request and will notify you when your file has been sent to be reviewed. The independent reviewer will render an opinion within 60 days upon receipt of all information. If you are not satisfied with the outcome of this review, you have the right to seek legal recourse.

IMPORTANT **The administrator, United of Omaha, has the exclusive right to interpret the provisions of the Intermediate PPO (with the exception of eligibility provisions), to construe its terms, to determine the amount and level of benefits payable thereunder, and to determine disability status as required for continuation as Class I dependent after age 24. The determination of the administrator is conclusive and binding.**

Section 11

When Coverage Stops

Employees and Retirees

Plan benefits for active and retired employees stop on the:

- Last day of the month that the employee's leave of absence or termination of employment becomes effective, **except** as provided under temporary continuation of coverage under COBRA or as otherwise provided by law or by the provisions of this SPD.
- Date the Plan is terminated
- Last day of the month that any cost of coverage is not paid when due
- Date of death
- Submission of a fraudulent claim

IMPORTANT

Health care coverage may be continued in some situations (refer to Continuation and Conversions, page 11-1, for COBRA rules).

Also, special rules apply to leaves of absence for family medical care (see "Family and Medical Leave Act" section of the Sandia Employee Benefits Binder) and USERRA.

Class I and Class II Dependents

Plan benefits for dependents stop on the:

- Last day of the month in which the dependent becomes eligible for coverage as an employee under any Plan
- Last day of the month that any cost of coverage for dependents is not paid when due
- End of the calendar year for which the Class II dependent is enrolled
- Date employee's or retiree's coverage stops[1]

[1] In this event, the dependent may be eligible for temporary continued coverage under COBRA (see Continuation and Conversions, page 11-1).

- Last day of the month in which the dependent spouse legally divorces or separates from the employee/retiree
- Last day of the month in which a dependent marries or ceases to be eligible under the definition of dependent[1]
- Last day of the month in which an employee or retiree terminates (disenrolls) dependent coverage

Refer to the Pre-Tax Premium Plan Booklet for specific rules regarding dropping dependent coverage if your medical contribution is taken on a pre-tax basis.

Termination by United of Omaha for Cause

United of Omaha may terminate a member's coverage for cause, upon 30 days written notice, or with written notice effective immediately for gross misconduct. Cause for termination of a member may include any of the following:

- Failure to pay copayments
- Permitting an unauthorized person to use your identification card (unless you notified United of Omaha that your card was lost or stolen)
- Repeated failure to make or keep appointments for medical care
- Declination of Plan benefits
- Abuse of Plan coverage by providing false information on applications or forms
- Failure to follow Plan rules and regulations
- Verbal or physical threats to a United of Omaha employee, physician, or network provider
- Fraudulent receipt of Plan services for noncovered persons
- Failure to comply with subrogation rules

Covered members terminated for cause are not eligible for any United of Omaha continuation or individual conversion.

[1] In this event, the dependent may be eligible for temporary continued coverage under COBRA (see Continuation and Conversions, page 11-1).

Certificate of Group Health Plan Coverage

When the Sandia BCSC learns of your loss of medical coverage, or the loss of coverage for your dependents, you will receive a Certificate of Group Health Plan Coverage. This certificate provides proof of your prior health care coverage for the past 18 months or less of coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the 6-month period before your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy an insurance policy for yourself or your family that does not exclude coverage for medical conditions that are present before you enroll.

This page intentionally left blank.

Section 12

Continuation and Conversions

If you lose or leave your job or an event occurs that would result in termination of coverage, Sandia makes available for employees/retirees and their dependents covered under the Plan the option to pay for continued benefit coverage for a specified period of time.

If, for any reason, you stop active work, contact the Sandia BCSC to determine what arrangements, if any, may be available for continued coverage under the Intermediate PPO. In some cases, there are special provisions for insureds to continue coverage. Also, Sandia complies with the federal law referred to as the Consolidated Omnibus Budget Reconciliation Act (COBRA) in which temporary continued coverage is provided to primary insureds and dependents who would otherwise lose group coverage due to specific events.

Subject to stated qualifications and requirements, coverage may be continued:

- During retirement
- During leaves of absence (LOA) (see below)
- During disability (see page 12-2)
- For surviving spouse and dependents (see page 12-3)
- For eligible persons under COBRA (see page 12-4)

During Retirement

Sandia pays the full cost of coverage for you and your covered dependents during retirement if you retired:

- Between January 1, 1988, and December 31, 1994, with a service or disability pension;
- Before January 1, 1988, with at least 15 years of service; or
- Between August 8, 1977, and January 1, 1988, at age 64 or older with at least 10 years of service as of age 65.

Retirees who retired with a service or disability pension after December 31, 1994, will share in the cost of coverage in this Plan. Call the BCSC for costs of coverage.

If you retire from Sandia but do not meet any of the above conditions, you may continue coverage by paying the full cost of coverage.

During Leaves of Absence

LOA for child care and family care—Sandia pays the employer portion of the premium for the Intermediate PPO for the first six months for employees on child care and family care leaves. Employees who remain on LOA beyond 6 months must pay the full premium to continue their medical benefits. For active employees, see detailed information in your *Sandia Employee Benefits Binder* under Family and Medical Leave Act.

LOA to the military—Sandia pays the employer portion of the premium for the Intermediate PPO for the first six months of leave. Employees who remain on military leave beyond the six months must pay the full premium to continue their medical benefits. If health coverage is not continued during the period of uniformed services leave, coverage would have to be reinstated upon return from leave.

All other LOAs—Coverage stops at the end of the month in which the LOA begins. Coverage may be continued at your own expense (paying full premiums) for the length of the approved LOA.

Coverage during the LOA runs concurrently with (i.e., applies toward) the temporary continued coverage explained under COBRA, page 12-4. If you terminate employment at the end of the LOA, additional coverage months may be available under COBRA depending on the number of months taken for the LOA.

During Disability

Disability Terminees—employees disabled after 1/1/82 and before retirement—who are eligible to receive benefits under the Sandia Long-Term Disability (LTD) Plan, receive coverage until the end of the month in which:

- The LTD recipient recovers and benefits cease,
- LTD benefits cease for any reason, or
- The LTD recipient dies.

If you retired with a disability:

- See Intermediate PPO and Medicare, page 9-1.
- See COBRA (page 12-4) about available temporary continued coverage when LTD benefits cease.

For LTD members eligible for primary Medicare coverage:

- Benefits are coordinated between Medicare and the Intermediate PPO (see page 8-1)
- The lifetime maximum on benefits applies (see page 9-3)
- The out-of-pocket provision does not apply (see page 9-3)

Sandia will pay for the majority of costs for the Intermediate PPO, however, you must pay a monthly premium share as well. Contact the Sandia BCSC at 505-845-2363 for information.

Surviving Spouse and Dependents

The following table contains the terms of Plan coverage for the surviving spouse and dependents at the time of death of on-roll regular employees and most retired employees.

Coverage	Surviving Spouse and Dependents	Dependent Children with No Surviving Parent
First 6 months	Employer portion paid for by Sandia	Employer portion paid for by Sandia
	EXCEPTION **The first 6 months of coverage for survivors of those retired employees paying their own premiums at the time of death are NOT paid for by Sandia.**	
Continued coverage	May continue coverage for life if elected in the first 6 months after employee's death. One half of the applicable group rate is paid by surviving spouses.	Option to purchase up to an additional 30 months of coverage can be obtained through COBRA.

Special Rules

- All Class I and Class II dependents covered at the time of death of the employee are eligible for coverage (see above).
- No new dependents can be added **unless** a qualifying COBRA event occurs within the first 36 months after the member's death. (Temporary continued coverage is explained under COBRA, page 12-4.)

- A survivor **cannot** add a Class II dependent even if that dependent is a Class I dependent at the time of the employee's death.
- The extension period for coverages under the Surviving Spouse Plan run at the same time with the temporary continued coverages explained under COBRA, page 12-4.

Termination Rules

For the surviving spouse and dependents, coverage terminates if:

- The spouse remarries — if remarriage occurs less than 36 months after the employee's death, spouse may have rights under COBRA (see below).
- A surviving spouse dies — if less than 36 months after the employee/retiree death, dependents may have rights under COBRA (see below).
- Payments are not received when due.

COBRA

The federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA) requires Sandia to offer a temporary extension of health care coverage to primary insureds and dependents who would otherwise lose their group health coverage as a result of certain events (see Events Causing Loss of Coverage, page 12-5).

The cost of continued coverage is paid by the insured at the applicable group rate plus a 2% administrative fee.

Qualified persons under COBRA are those covered under this Plan **the day before** the events causing loss of coverage. Qualified persons include:

- You (the employee)
- Your spouse
- Your Class I and Class II dependent children, as defined on page 2-4.
- Newborns, adopted children, or a child placed for adoption with the covered employee, even if enrolled after initial COBRA event

If you have another group plan or Medicare on the date of your qualifying COBRA event, you may still be eligible for COBRA. However, your other group health plan or Medicare would provide your primary coverage, and the Intermediate PPO would provide only secondary coverage.

Events Causing Loss of Coverage

The following table describes the events causing loss of coverage for terminees, surviving spouses, and dependents. The length of time of the optional COBRA coverage is noted.

If you are the . . .	and if you, the insured, lose Intermediate PPO coverage because of . . .	then, under COBRA you have the right to choose temporary continued coverage for a maximum of . . .
employee and his or her Class I or II dependent, i.e., spouse, or a dependent child	■ a reduction in the number of hours of employment at Sandia, ■ voluntary termination of employment,	18 months (when a 36-month COBRA event occurs during an 18-month continuation, coverage may be extended for 36 months from the original COBRA qualifying event date)
employee and his or her Class I or II dependent, i.e., spouse, or a dependent child	■ termination of employment, and you are disabled or become disabled within the first 60 days of your COBRA coverage, as determined by Social Security[1] and you do not have Medicare coverage,	29 months from the original qualifying event (after the first 18 months you will be charged 150% of the cost of the applicable group rate)
spouse	■ the death of the Sandia employee/retiree (see page 12-3), ■ a divorce or legal separation from a Sandia employee/ retiree,	36 months
Class I or II dependent	■ the death of a Sandia employee/retiree (see page 12-3), ■ a change in eligible status (i.e., dependent ceases to be a dependent child under the Intermediate PPO, such as stepchildren of divorced parents, eligible dependent of surviving spouse who dies),	36 months

Notification and Election of COBRA

The following table shows notification and election actions for temporary continued coverage under COBRA.

[1] You must notify the Sandia BCSC at 845-BENE (2363) within 60 days of the date Social Security determines that you or a family member is disabled and within the first 18 months of COBRA continuation of coverage. If you fail to notify Sandia, you will lose your right to the additional COBRA coverage.

Step	Who	Action
1	Employee or family member	Notify Sandia BCSC in writing within 60 days[1] of ■ divorce, ■ legal separation, ■ loss of a child's dependent status, ■ disability designation by Social Security, ■ death of a primary covered participant other than an employee.
2	Sandia Benefits Department	Notify Sandia BCSC of covered participant's ■ death, ■ termination of employment.
3	Sandia BCSC	Notify participants that they have the right to choose continued coverage within 60 days from latest of the following dates: ■ notification by Sandia BCSC, ■ coverage actually ends.
4	Covered participant	Contact the COBRA Administrator at Sandia to elect COBRA coverage. ■ Covered participant has 60 days to elect COBRA from the latter of the date of the notice or their loss of coverage date, whichever is later. ■ Covered participant has 45 days from the election date to make first premium payment and a 30-day grace period every month thereafter. ■ **If you elect continued coverage**, then Sandia provides coverage under the Plan **at your expense** plus the applicable administrative fee. **Note:** See Coverage for Surviving Spouses and Dependents, page 12-3. ■ **If you do not elect continued coverage,** then group coverage under the Plan ends.

The following benefits apply to COBRA participants:

- A Qualified Beneficiary (QB) is entitled to the same coverage as he/she had before the mid-year election change event (see the Pre-Tax Premium Plan Booklet for a definition).
- They have the same open enrollment period rights as similarly situated active employees.
- If coverage is modified for similarly situated active employees, the coverage for COBRA beneficiaries is modified in the same manner.
- If the employer discontinues the plan or benefit package under which the QBs were receiving benefits, they must still be able to receive different employer-provided coverage.
- QBs receiving COBRA coverage have the same right to enroll family members under HIPAA special enrollment rules as active employees and plan participants.

[1] If you fail to inform the Sandia BCSC within 60 days of the notification date, you will no longer be eligible to participate in COBRA.

- If COBRA participants move out of the network area, they will have the same coverage available to other insureds living out of the network area.

Termination of Temporary Coverage

Temporary continued coverage under the Plan provisions for COBRA participation may be terminated before the full 18, 29, or 36 months of coverage when:

- Sandia no longer provides coverage to any employee
- The premium for continued coverage is not paid
- The insured becomes covered under another group health plan or Medicare before COBRA coverage would otherwise end. However, you do not lose the right to COBRA coverage if the new group health plan does not cover illness or conditions because you had them before you became covered under the Plan. However, the other group health plan would provide your primary coverage; the Intermediate PPO would provide only secondary coverage.
- The insured is eligible and enrolls for Medicare coverage Parts A and B (i.e., Medicare is primary)
- Submission of a fraudulent claim

Coverage extensions required under other laws (e.g., state law) or provided by other provisions of this Plan, such as leaves of absence or the Surviving Spouse Plan, continue concurrently with (i.e., count toward) temporary continued coverage, mandated by COBRA.

Disability Extension and Multiple Qualifying Events

COBRA coverage may be extended under the following circumstances:

- If an individual is Social Security disabled before or during the first 60 days of an 18-month COBRA period, all of the individual's COBRA-eligible family are eligible for an 11-month extension of coverage. This includes children born or adopted after the initial COBRA event. The individual must provide a copy of the Social Security determination within 60 days of the date the disability determination was made and no later than 18 months after the mid-year election change event. He/she must also provide notice within 30 days of determination that person is no longer disabled.
- In the event of a second mid-year election change event (e.g., divorce, covered employee dies or becomes covered by Medicare, dependent child loses dependent status) that occurs during the 18-month COBRA coverage period (or during disability extension), the spouse and children already receiving continuation coverage may be eligible for additional months of coverage, up

to a maximum of 36 months from the date of the original mid-year election change event. The employee must notify the Sandia BCSC of the second mid-year election change event within 60 days.

Conversion Coverage

If you have been covered under the Plan for at least 3 months and coverage ends for reasons other than nonpayment of premiums, **then** you may apply to the Claims Administrator for individual coverage under a converted policy without submitting evidence of good health. You are also eligible for conversion coverage after COBRA coverage ends.

This conversion coverage does not provide the same benefits as those provided by the Intermediate PPO.

The rules for applying for conversion are as follows:

- The form and terms of the converted policy are determined by the Claims Administrator at the time you apply for conversion.
- You must apply to the Claims Administrator within 31 days after coverage under the Intermediate PPO terminates.
- You must pay for the cost of coverage.
- The converted policy becomes effective on the day after coverage under the Intermediate PPO terminates.
- If issuing a converted policy results in over-insurance (when covered individuals can recover total benefits that exceed their actual medical expenses) or duplication of benefits, the Claims Administrator may refuse to issue a converted policy.

Section 13

United of Omaha Administrative Services

United of Omaha provides the following administrative services:

- Customer service
- Identification cards
- ERISA information
- Plan identification information

Customer Service

United of Omaha Group Customer Service (see Appendix F for contact information) provides assistance to insureds. Customer Service consists of trained representatives who can help insureds in the following areas:

- Obtaining identification cards
- Obtaining Plan benefit information
- Inquiring about claims
- Verifying eligibility
- Inquiring about provider networks
- Providing a hardcopy of the provider directory
- Resolving complaints

Identification Cards

You will receive two Intermediate PPO identification cards per family. Additional identification cards may be requested by calling United of Omaha Customer Service at 1-800-488-0167. The Intermediate PPO Identification Card identifies you to providers as an eligible Plan insured. This card contains the following:

- Your name and Social Security number
- Customer Service precertification and Behavioral Health Program phone numbers
- The group contract number you are enrolled in
- The claims filing address

Always present your Intermediate PPO identification card when obtaining health care.

Appendix A

Prescription Drug Program

The Prescription Drug Program (PDP), although part of the Intermediate PPO, is administered separately by Eckerd Health Services (EHS). The PDP is available only to Intermediate PPO insureds. Any licensed provider is legally authorized to prescribe medications to issue your prescription.

The following chart summarizes the copayments and coinsurances with minimum and maximum copayments as well as coverages for purchases under the Mail-Order Program and the EHS network and out-of-network retail pharmacies.

Mail-Order Program	EHS Network Retail Pharmacies	Out-Of-Network Retail Pharmacies
For maintenance prescription drugs ■ $12 copayment for generic prescription drugs ■ $38 copayment for preferred formulary brand-name prescription drugs ■ $68 copayment for nonpreferred brand-name prescription drugs ■ Maximum of 90-day supply	■ Coinsurance of 20% of retail discount price with a $6 minimum and $9 maximum for generic prescription drugs ■ Coinsurance of 30% of retail discount price with a $17 minimum and $27 maximum for preferred formulary brand-name prescription drugs ■ Coinsurance of 40% of retail discount price with a $30 minimum and $40 maximum for nonpreferred brand-name prescription drugs ■ Maximum of 30-day supply	■ 50% reimbursement of retail network price, less the applicable minimum retail network copayment ■ Maximum of 30-day supply ■ File your claims with Eckerd Health Services ■ Coinsurance does not apply to Intermediate PPO deductible and out-of-pocket maximum

IMPORTANT

If the cost of the prescription is less than the copayment, you will pay only the actual cost of the prescription.

Copayments do not apply to Intermediate PPO deductible and/or out-of-pocket maximum.

A formulary is a list of preferred brand name drugs that can meet a patient's clinical needs at a lower cost than other brand name drugs. Formulary medications are selected according to safety, efficacy (whether the drug works for the indicated purpose), therapeutic merit (how appropriate the drug is for the treatment of a particular condition), current standard of practice, and cost. The EHS Pharmacy and Therapeutics (P&T) Committee is responsible for making recommendations on all formulary additions and deletions. A thorough review of pharmaceutical and medical literature supports the evaluation of all drugs proposed for addition to the EHS formulary. Comparative data associated with the drug's efficacy, therapeutic advantages and deficiencies, adverse effects, and cost are presented to the P&T Committee for an unbiased evaluation. When a drug is added to the formulary, an evaluation is made of all drugs from the therapeutic class to determine if any drugs should be removed as a result of the new addition. The P&T Committee meets to conduct therapeutic class reviews each quarter and changes may be made based on their findings.

The formulary is the same for both the Mail-Order Program and the retail network pharmacies and is comprehensive for all major categories of acute and maintenance medication. To find out if a drug is on the formulary list, call EHS at 1-888-249-5041 or look on the Web at www.ehs.com under "Member Services." Select "Searchable Formulary" under Member Services and select "Preferred Drug Alternative Guide." If you would like to have a copy of the EHS Preferred Drug List, contact the Sandia Benefits Customer Service Center or the Sandia/CA Benefits Office. Drugs listed on the EHS formulary may or may not be covered under the PDP, refer to the Covered/Noncovered Drugs Sections in this appendix.

If, for some reason, you are unable to take any of the formulary alternatives to a nonpreferred drug, you may have your physician write a letter of medical necessity as to what medications you have tried and why they didn't work. This letter can be faxed to the Clinical Pharmacy Department at EHS at 412-967-1512 or mailed to EHS, 620 Epsilon Drive, Pittsburgh, PA 15238. EHS will review the letter and make the decision as to whether you will be able to receive the nonpreferred drug for the preferred formulary brand-name coinsurance/copayment amount.

Important Changes in the Prescription Drug Program

- Copayments for mail-order have increased. Copayment maximums for retail have increased.

Eligibility

Insureds eligible for coverage under the Intermediate PPO are eligible for the Prescription Drug Program. Intermediate PPO members who have primary prescription drug coverage under another group health care plan **are not eligible** to use the Mail-Order Program or purchase drugs from retail network pharmacies at the copayment benefit.

Coordination of benefits will apply. If you or your dependent has primary prescription drug coverage elsewhere, file the claim first with the appropriate plan, and then file with EHS, attaching a copy of the EOB. EHS will allow 50% of the price submitted, with no days-supply limit, up to the amount the insured pays out-of-pocket.

Covered Prescriptions

FDA approval of a drug does not guarantee inclusion in the PDP. New drugs may be subject to review before being covered under the PDP or may be excluded based on plan guidelines and policies.

To be covered, the prescription must be considered medically necessary.[1] The PDP covers the following categories of drugs:

- Federal Legend Drugs—A medicinal substance that bears the legend "Caution: Federal Law prohibits dispensing without a prescription."
- State Restricted Drugs—A medicinal substance that, by state law, may be dispensed by prescription only.
- Compounded Medications—A compounded prescription in a customized dosage form that contains at least one federal legend drug.
- Insulin and Diabetic Supplies—including lancets, alcohol swabs, test-strips, and syringes can be purchased in-network **with a prescription**, with a copayment, or they can be purchased in-network, **without a prescription**, by paying the full price and submitting the claim to EHS for reimbursement. (You will be reimbursed down to the appropriate copayment.) The Mail-Order Program is also available for insulin and diabetic supplies purchased **with a prescription**.

[1] For the PDP, medically necessary is defined as follows:
- appropriate for the symptoms, diagnosis, or treatment of the eligible person's condition
- provided for the diagnosis, direct care, or treatment of the eligible person's condition
- not primarily for the convenience of the eligible person and/or the provider
- the most appropriate supply or level of service that safely can be provided to the eligible person

Note— Medicare covers lancets and test strips.

- Novopen
- Insulin "auto-injectors" except for implantable insulin pumps
- Syringes
- Oral contraceptives
- Diaphragms
- Oral calcium supplements for clinically documented hypoparathyroidism (see page A-5)
- Niferex (see page A-5)
- Prescription smoking-deterrent products prescribed from four weeks to twenty weeks and limited to two courses of therapy per lifetime
- Vaccines (at retail only)
- Prescription vitamins (see page A-5)
- Retin A/Renova/Differen (see page A-5)
- Viagra (for male participants only), limited to 8 pills every 30 days at retail and 24 pills every 90 days by mail (see page A-5)

Note— Certain drugs (examples include Imitrex, Ritalin, Zomig, Amerge, and Toradol) are subject to quantity restrictions per established EHS clinical guidelines. If the prescription exceeds these clinical quantity restrictions, the physician must submit a letter of medical necessity supporting the need for medication beyond the clinical guidelines. EHS reserves the right to challenge any prescription that may put a patient at risk or appears to be a situation of abuse.

Prescriptions Requiring Prior Authorization

The following prescriptions will be dispensed through the Mail-Order Program or a retail pharmacy when medically necessary with an appropriate diagnosis. This list is not all-inclusive and is subject to change as new drugs are released to the market.

- Anabolic steroids
- B-12 injectables

- Biologicals–immune globulins
- Diet medications
- Growth hormones
- Osteoarthritis agents
- Oral calcium supplements for hypoparathyroidism only
- Prescription vitamins
- Zyvox
- Wellbutrin-SR
- Proscar
- Retin A/Differen/Avita (if under age 26, no medical diagnosis required)
- Thalomid (dispensed at retail only)
- Niferex
- Lovenox
- Enbrel
- Rebetron
- Botox

Noncovered Prescriptions

In addition to the clinical guideline limitation imposed by Eckerd Health Services (see Covered Prescriptions, page A-3), the PDP excludes coverage for certain drugs, supplies, and treatments, which include but are not limited to the following:

- Over-the-counter medications
- Fluoride preparations, dental rinses, Tri-Vi-Flor
- Contraceptive foams, jellies, and ointments
- Drugs labeled "Caution: Limited by Federal Law to investigational use," or "Experimental Drugs"
- Glucose tablets
- Drugs used for cosmetic purposes
- Over-the-counter vitamins and minerals

- Prescription drugs that may be properly received without charge under local, state, or federal programs, including Workers' Compensation
- Refills of prescriptions in excess of the number specified by the physician
- Refills dispensed after one year from the date of order by the physician
- Prescription drugs purchased for insureds who are ineligible for coverage under the Intermediate PPO
- Prescription drugs taken by a donor who is not insured under the Intermediate PPO
- Medicine not medically necessary for the treatment of a disease or an injury

The following are excluded by the PDP but may be covered by the Intermediate PPO if medically necessary:

- Medication that is dispensed and/or administered by a licensed facility or provider such as a hospital, home health care agency, or physician's office, and the charges are included in the facility or provider bill to the Intermediate PPO Claims Administrator
- Medical supplies such as ostomy supplies, support hose, orthotics, etc.
- Therapeutic devices or appliances such as glucometers and respiratory therapy devices
- Food supplements
- Implantable birth control devices such as Norplant and IUDs
- Allergy serum
- Intravenous medications
- Lancet "auto-injectors"
- Implantable insulin pumps

Experimental Drugs

For the PDP, experimental drugs are defined by the following:

- The drug cannot be lawfully marketed without approval of the United States Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug is furnished;
- Reliable evidence shows that the drug is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or

- Reliable evidence shows that the consensus among experts regarding the drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnosis; or

- The drug is used for a purpose that is not approved by the FDA, with the exception that no drug shall be denied coverage on the basis that the drug has not been approved by the FDA for the treatment of the particular indication for which the drug has been prescribed, provided that the drug has been recognized as safe and effective for the treatment of that indication in (a) one or more of the standard medical reference compendia, including the "AMA Drug Evaluations," the "American Hospital Formulary Service Drug Information," and "Drug Information for the Healthcare Provider," or (b) at least two articles from major peer-reviewed professional medical journals, provided that no article has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed; or

- Coverage for any drug if the FDA has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed; or

- Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature listed above; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug; or the written informed consent used by the treating facility or by another facility studying substantially the same drug.

Mail-Order Program

Tip

Let your physician know that you are planning to use the Mail-Order Program services and request a 90-day prescription (with up to 3 refills). Verify that the prescription specifies the exact information for daily dosage, strength, quantity (e.g., number of pills, inhalers, tubes), and number of refills.

The Mail-Order Program is a licensed pharmacy (Express Pharmacy Services [EPS] in Pittsburgh, Pennsylvania) specializing in filling prescription drug orders for maintenance prescriptions. Registered pharmacists are available 24 hours a day, 7 days a week at 1-888-249-5041 to answer patients' medication-related questions. Prescriptions are delivered to the insured's home. (You are not responsible for shipping and handling fees unless you request special shipping arrangements.)

IMPORTANT

Prescriptions with dosages that exceed the 90-day supply as determined by the EPS usual and customary (U&C) guidelines will be filled as one 90-day supply and the remainder will be treated as refills. A copayment applies for each 90-day prescription and for each refill.

Maintenance prescription drugs are those taken routinely over a long period of time for an ongoing medical condition. To obtain a maintenance prescription through the Mail-Order Program, you will pay the appropriate copayment for each prescription up to a 90-day supply. Over-the-counter medications are **not** covered except where specifically listed as covered.

If you send in a prescription through the Mail-Order Program and EPS does not carry the medication or if it is out of stock and EPS does not anticipate getting the medication in a timely manner, you will be allowed to receive a 90-day supply at a retail network pharmacy for the applicable mail-order copayment. Contact EHS at 1-888-249-5041 for assistance.

Note—If you are a patient in a nursing home that does not accept mail-order prescriptions, contact EHS to make arrangements to receive up to a 90-day supply of medication at a retail network pharmacy for the applicable mail-order copayment. You must provide proof of residency in a nursing home.

If you are a cystic fibrosis patient, you can receive up to a 90-day supply at a Cystic Fibrosis Foundation pharmacy for the applicable mail-order copayment by contacting the Sandia BCSC.

Ordering and Receiving Prescriptions

Step	Action	
1	**Forms**	Obtain a Mail Service Prescription Enrollment Order Form from the Sandia BCSC, Sandia Line, or the Web. (Refer to Appendix F for instructions.)
2	**Ordering Original Prescriptions**	■ Complete the Mail Service Prescription Enrollment Order Form ■ Attach your **original** written prescription (with your Social Security number and address written on the back). Your physician must write the prescription for a 90-day supply with applicable refills, **not** a 30-day supply with refills. ■ Enclose the required copayment using a check or money order, or a charge card number for Visa, MasterCard, JC Penney, American Express, or Discover/Novus ■ Mail all to EPS at Express Pharmacy Services, PO Box 2860, Pittsburgh, PA 15230-2860, or use the preaddressed, postage-paid envelope. Your physician may also call in the prescription to EHS at 1-888-249-5041 or fax it to 816-891-8596.
	Note— If you have previously ordered medications through EPS, you can use either the Mail Service Prescription Enrollment Order Form or the Prescription Order Form attached to the bottom of your customer receipt sent by EPS with your previous order. If any new drug allergies or medical conditions have developed since your last order, indicate this on the Mail Service Prescription Enrollment Order Form or the back of the Prescription Order Form.	
3	**Delivery**	Expect delivery to your home by first-class mail or second-day carrier within 14 days from the **date you mail your order**. An adult's signature may be required for acceptance.
4	**Refills**	Refilling a mail-order prescription can be done by phone, by fax, by mail, or through the Web. It is recommended that you order **3 weeks** in advance of your current mail service prescription running out. Suggested refill dates will be included on the customer receipt that you receive from EPS. **Refill-by-Phone:** Call toll-free (1-800-222-3383) to order refills. You may use the automated refill system 24 hours a day. Customer service representatives are available 24 hours a day from 12:00 A.M. (EST) Monday through 12:00 P.M. (EST) Friday. They are also available from 9:00 A.M. to 8:00 P.M. (EST) on Saturday, and 9:00 A.M. to 6:00 P.M. (EST) on Sunday. When you call, be ready to provide the primary participant's Social Security number, prescription number, and a Visa, MasterCard, JC Penney, American Express, or Discover/Novus credit card number. **Refill-by-Fax:** Complete the Prescription Order Form (attached to the bottom of your customer receipt), making sure you either adhere the refill label provided or write the prescription number in the space provided. Fax the form to 1-800-323-0161. **Note:** Schedule II prescriptions cannot be faxed.

Step	Action	
		Refill-by-Mail: Complete the Prescription Order Form (attached to the bottom of your customer receipt), making sure you either adhere the refill label provided or write the prescription number in the space provided. Mail in the self-addressed, postage-paid envelope. **Refill through the Web:** Go to www.ehs.com/refills and follow the instructions. You will need to use one of the acceptable credit cards for payment. To renew a prescription after all refills have been exhausted, follow the instructions listed on the Prescription Renewal Form that is sent by EPS with your last available refill.

Generic or Brand-to-Brand Substitution

Every prescription drug has two names: the trademark, or brand name; and the chemical, or generic name. By law, both brand-name and generic drugs must meet the same standards for safety, purity, strength, and quality. (**Example:** tetracycline is the generic name for a widely used antibiotic. Achromycin is the brand name.)

Many drugs are available in generic form. Generic drugs offer substantial cost savings over brand names; therefore, the Mail-Order Program has a generic substitution component. **Unless your doctor has specified that the prescription be dispensed as written, your prescription will be filled with the least expensive acceptable generic equivalent when available and permissible by law.** If you receive a generic medication in place of the brand-name medication, and you want the brand-name medication, you will need to obtain a new prescription stating "no substitution" or "dispense as written" and resubmit it along with the required copayment.

Alternatively, some brand-name drugs have other less expensive brand-name drugs that are acceptable therapeutic equivalents. When these are available, the least expensive acceptable brand-name drug will be substituted for a more expensive brand-name drug when permissible by law, and **you** and **your doctor** agree with the substitution.

EXCEPTION

This provision does not apply to brand-name drugs that do not have an FDA A- or AB-rated generic equivalent available.

Retail Network Pharmacies

Retail network pharmacies are available for those insureds who need **immediate, short-term** prescription medications, and/or prescription medications that

cannot be shipped through the mail. When purchasing a prescription through one of the retail network pharmacies, you will pay a copayment at the time of purchase (see Using the Network Retail Pharmacies, page A-12).

National Chains

EHS has contracted with specific retail pharmacies across the nation that will provide prescriptions to Sandia at discounted rates. These pharmacies are known as **retail network pharmacies**. All locations of the following **national chain** pharmacies participate in the network:

A & P
Albertson's
Arbor
Arrow
Bartell Drug
Brooks
Brookshire
Costco
Cub Pharmacies
CVS
Dillon Stores
Dominick's
Drug Emporium
Duane Reade
Eckerd Drug
Fred's, Inc.
Fred Meyer
Giant Eagle
Grand Union
Happy Harry's
H.E.B.
Health Mart
Hy-Vee/Drug Town
K-Mart
Kerr Drug
King Soopers
Kroger Pharmacies
Leader Drug
Long's
Medicap
Medicine Shoppe
Meijer Pharmacies
NeighborCare
Pathmark
Phar Mor
Publix
Raley's
Randall's
Rite Aid
Rx Plus
Safeway
Schnuck's
Sentry
ShopKo
Shoprite
Smith's Food & Drug
Stop & Shop
Super D
Snyder
Target Stores
Tom Thumb
Von's
Walgreen Drug Stores
Wal-Mart Pharmacies
Wegman's
Weis Pharmacies
Winn Dixie

Regional Chains in New Mexico

These are the participating regional pharmacy chains in the state of New Mexico:

American/Osco/Sav-on
Horizon Pharmacies
Regent Drugs of New Mexico

Regional Chains in California

These are the participating regional pharmacy chains in the state of California:

Caremark Pharmacies
CBC Professional Pharmacies
Chronimed Pharmacies
Gemmel Pharmacies
HMI Pharmaceutical Services
Med-Rx Drugs
Merrill's Drug Centers
Pharmacy Factors
Costco Pharmacies
Price Less Drug Stores
Rite Aid
Sav Mart Pharmacies
Save Mart Pharmacies
Sharp Rees-Stealy Pharmacies

Independent Pharmacies

Many independent pharmacies are included in the network. Call EHS at 1-888-249-5041 or visit www.ehs.com to find out if your neighborhood pharmacy belongs to the network.

Using the Network Retail Pharmacies

To obtain a medication through a retail network pharmacy, you will need a written prescription from your doctor. Present the prescription **and your EHS ID card** to the pharmacist. The **card is required** to identify you as an insured in order to remit the appropriate copayment.

IMPORTANT **If you do not show your EHS ID card at a retail network pharmacy, you will be required to pay the full nondiscounted price and you** *cannot* **submit this to the Intermediate PPO Claims Administrator or EHS for reimbursement.** *Note: Many pharmacies will process your claim electronically and refund your claim down to your copayment within 7 days of purchase if you forget to show your ID card. To obtain an EHS ID card, call 1-888-249-5041.*

If you request a prescription to be filled in a retail network pharmacy for more than a 30-day supply, the pharmacist will fill only 30 days for the appropriate coinsurance of 20%, 30%, or 40% (minimum and maximum copayments apply) and hold the rest as refills. When you need a refill, return to the pharmacy, pay another coinsurance/copayment amount, and receive another maximum 30-day supply (or up to the amount prescribed by the physician).

Example: You obtain a prescription for a 100-day supply of a generic medication. The pharmacist will fill an initial 30-day supply for the 20% coinsurance amount or the applicable minimum or maximum copayment. Thereafter, the prescription will be filled in monthly intervals, up to a 30-day supply, for the 20% coinsurance amount or the applicable minimum or maximum copayment.

Coinsurance and Minimum/Maximum Copayments for Prescriptions Purchased in a Network Pharmacy

The coinsurance copayment amounts for retail network pharmacy prescriptions for CY 2003 are 20% of the retail discount price with a $6 minimum and $9 maximum for **generic** prescriptions, 30% of the retail discount price with a $17 minimum and $27 maximum for **preferred formulary brand-name** prescriptions, and 40% of the retail discount price with a $30 minimum and $40 maximum for **nonpreferred brand-name** prescriptions, for up to a 30-day supply. No paper claim filing is required, and coinsurance/copayments **cannot** be submitted to the Intermediate PPO Claims Administrator or EHS for reimbursement. Coinsurance/copayments do not apply to the Intermediate PPO deductible or to the out-of-pocket maximum. Coinsurance/copayments are required for each prescription, whether it is an original or a refill.

Note—If the cost of the prescription is less than the minimum copayment, you will pay only the actual cost of the prescription. For example, if you ordered a nonpreferred brand-name drug that costs $20 but the copayment is $30, you will only have to pay the $20. The $20, consistent with the treatment of coinsurance/copayments, CANNOT be submitted for reimbursement.

Using the Out-of-Network Retail Pharmacies

Using an Out-of-Network Pharmacy

If you choose to purchase a prescription through an out-of-network pharmacy, you will be reimbursed 50% of the retail network price, less the applicable minimum retail copayment, for up to a 30-day supply. Any amounts over a 30-day supply will be denied.

The 50% coinsurance will not apply to the out-of-pocket maximum under the Intermediate PPO.

If you have a prescription filled by an out-of-network pharmacy, complete a PDP Direct Reimbursement Form, attach pharmacy receipts, and send your claim to:

Eckerd Health Services
PO Box 2860
Pittsburgh, PA 15230-2860

EHS will process your claim upon receipt. Once the claim has been processed, the insured will receive payment, if applicable, and an Explanation of Benefits (EOB) from EHS, which will include information about the claim (covered, denied, etc.).

IMPORTANT **No claims will be paid for charges incurred more than one year before the date of the claim submission.**

Appealing a Claim Denial

If you have a claim denied because of . . .	then . . .
■ eligibility[1]	■ contact the Sandia BCSC
■ Plan provisions	■ contact EHS
■ any other reason	■ contact EHS

If a paper claim for some or all of the benefits is denied, Eckerd Health Services must provide the insured with:

- Written notice of the specific reasons for the denial
- Reference to the pertinent PDP provisions.

You, your dependent, or other duly authorized person may appeal this denial or other action in writing within 180 days after your receipt of notification of Eckerd Health Services' decision if:

- A claim for benefits is denied in full or in part, or
- You or your dependents feel you have been treated unfairly with respect to any part of the PDP.

[1] See Appeals, page 2-6.

Send a written request for review of any denied claim or other disputed matter directly to:

Eckerd Health Services
Attn: CAT Team
100 Delta Drive
Pittsburgh, PA 15238

Eckerd Health Services has the exclusive right to interpret the provisions of the PDP, and that decision is conclusive and binding.

This is the procedure for appealing denial of claims:

Step	Who	Action
1	Insured or authorized representative	Submit to Eckerd Health Services within 180 days after receipt of the denial ■ a request for reconsideration (appeal) ■ documents or records in support of the appeal **IMPORTANT—The insured and his or her representative are entitled to review related documents.**
2	Eckerd Health Services	For timeframes for response from the Claims Administrator, see Appendix B.

IMPORTANT **The administrator, Eckerd Health Services, has the exclusive right to interpret the provisions of the Prescription Drug Program, to construe its terms, and to determine the copayments and coverages for purchases payable thereunder. The determination of the administrator is conclusive and binding.**

This page intentionally left blank.

Appendix B

Response from Claims Administrator

The Claims Administrator must respond or provide notice of claims and appeals decisions within a certain period of time. This appendix provides you with those timeframes for both claim decisions and appeal decisions.

Claim Decision Procedures

The following outlines response timeframes for decisions from the Claims Administrator for various claim situations. There are urgent claims and non-urgent claims. Non-urgent claims may be "pre-service" claims (i.e., obtaining predeterminations for treatment), "post-service" claims, and "concurrent care" claims (i.e., requesting additional treatment sessions for previously approved services).

Urgent Care Claims

Timeframe For Response From Claims Administrator

Urgent claims will be decided as soon as possible. Notice of the decision (whether adverse or not) must be provided, considering medical exigencies, no later than 72 hours after receipt of the claim.

Extensions

If additional information is needed to make a claim decision, the Claims Administrator may extend the timeframe for providing a response by up to 48 hours from the time the information is received or the initial period expires.

Period for Claimant to Complete Claim

If an extension in processing is required because the claimant has failed to submit sufficient information to allow determination of the claim, the claimant has at least 48 hours after receipt of notice to provide missing information

Other Related Notices

Notice that a claim is improperly filed or is missing information must be provided as soon as possible but no later than 24 hours from receipt of the claim.

Non-urgent Pre-service Claims

Timeframe For Response From Claims Administrator

Pre-service determinations of benefit (whether adverse or not) must be provided within a reasonable period of time, appropriate to the medical circumstance, but no later than 15 days.

Extension

The Claims Administrator may extend the original timeframe by up to 15 days if necessary due to matters beyond the Plan's control. The Claims Administrator must provide an extension notice before the initial period ends.

Period for Claimant to Complete Claim

If an extension in processing is required because the claimant has failed to submit sufficient information to allow determination of the claim, the claimant will be so notified and given at least 45 days from receipt of the notice to provide missing information.

Non-urgent Post-service Claims

Timeframe For Response from Claims Administrator

Post-service claim decisions notices (whether adverse or not) must be provided within a reasonable period of time but no later than 30 days.

Extension

The Claims Administrator may extend the original timeframe by up to 15 days if necessary due to matters beyond the Plan's control. The Claims Administrator must provide an extension notice before the initial period ends.

Period for Claimant to Complete Claim

If an extension in processing is required because the claimant has failed to submit sufficient information to allow determination of the claim, the claimant will be so notified and given at least 45 days from receipt of the notice to provide missing information.

Concurrent Care Claims

Timeframe For Response from Claims Administrator

Concurrent care adverse claim decisions must be provided sufficiently in advance to give claimants an opportunity to appeal and obtain a decision before the benefit is reduced or terminated. A request to extend a course of treatment will receive a response within 24 hours, if the claim is made at least 24 hours prior to the expiration of the period of time or number of treatments.

Appeal Decision Procedures

The Intermediate PPO plan provides insureds with two levels of appeal if a claim has been denied (see page 10-2). The following outlines response timeframes by the Claims Administrator (including prescription drugs) for appeals to decisions involving various situations. Appeals may apply to urgent care claims or non-urgent care claims. Non-urgent claim appeals may either be for "pre-service" claim decisions (i.e., a decision on a predetermination request), "post-service" claim decisions, and "concurrent care" claim decisions (i.e., requesting additional treatment sessions for previously approved services).

Urgent Care Claims

Period for Filing Appeals

The claimant has at least 180 days for filing the first level of appeal.

Timeframe For Response From Claims Administrator

Response must be provided as soon as possible, taking into account medical exigencies, but no later than 72 hours. There is a maximum of two levels of mandatory review.

Non-urgent Pre-service Claims

Period for Filing Appeals

The claimant has at least 180 days for filing the first level of appeal.

Timeframe For Response From Claims Administrator

Response must be provided within a reasonable period of time, appropriate to medical circumstances, but no later than 30 days. Response must be provided within 15 days of each appeal.

Non-urgent Post-service Claims

Period for Filing Appeals

The claimant has at least 180 days for filing the first level of appeal.

Timeframe For Response From Claims Administration

Response must be provided within a reasonable period of time, but no later than 60 days. A notice of adverse claim appeal decisions must be provided within a reasonable period of time, but no later than 30 days after each appeal.

Contents of Notice or Response from Claims Administrator

The notice will include all of the following:

- The specific reason(s) for the denial
- Specific references to the Plan provision(s) upon which the denial is based
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary
- An explanation of the Plan's appeal procedure, its deadlines, including, if applicable, the expedited review available for urgent claims, and the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse decision on appeal
- A copy of any rule or guideline relied upon in making the adverse determination, or a statement that the rule or guideline was relied upon and will be provided, upon request, free of charge
- If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request

If the claimant does not receive a written response from the Claims Administrator within the time periods described above, the claimant should treat the claim as denied and proceed immediately to the next level of appeal, request an external review, or seek legal recourse.

This page intentionally left blank.

Appendix C

Insured's Rights and Responsibilities

1. Receive quality health care that uses current technologies and treatment practices.
2. Expect accessible, clean, and safe offices that offer adequate seating and privacy.
3. Expect your doctor and his/her staff to demonstrate respect and common courtesy when you are treated.
4. Expect your doctor to tell you about what is happening during your care and to clearly describe the diagnosis and treatment options available.
5. Get clear answers to your questions.
6. Be included in the decisions that affect your health. When making these decisions, your doctor should inform you about the diagnosis, prognosis, treatment, treatment risks, alternatives to treatment, and associated risks.
7. Choose to participate in research studies.
8. Be informed about available preventive health services and programs designed to improve and maintain your health status and quality of life.
9. Refuse treatment, to the extent permitted by law, and to be told of the potential medical impact of such action.
10. Request and receive an itemized list of services charged to you.
11. Expect your medical records to be accurate and organized.
12. Inspect your medical records.
13. Voice complaints about a doctor, the health care setting, or the health plan. A response or action to your complaint should occur within a reasonable time.
14. Be given information about the organization, its services, accessibility, service changes, health plan coverage, and the available doctors.
15. Receive information that is readable and easily understood.
16. Expect your medical records to be kept private.
17. Choose any one of United of Omaha's contracted doctors.
18. Expect to be given a doctor's appointment within a reasonable amount of time. You should also not have to wait in the office for a long time.
19. Get timely medical care and to give your doctor the chance to prevent avoidable complications.

20. Provide accurate and complete information that helps doctors take care of you. This information includes your present symptoms, past illnesses and treatments, past hospital stays, allergies, and current medications.
21. Follow your doctor's instructions in prescribing health care services to you.
22. Participate in preventive health programs and health services counseling that help improve and maintain your health.
23. Keep appointments, or give as much notice as possible of late arrivals or cancellations.
24. Treat all medical staff with consideration and courtesy.
25. Fill out insured satisfaction surveys and use grievance procedures if you want to let others know how you feel about the quality of service given.
26. Keep your record updated with accurate personal data, including changes in name, address, telephone numbers, and increases and/or decreases in dependents.

Appendix D

Intermediate PPO Acronyms and Definitions

Acronyms

BCSC	Benefits Customer Service Center
CCN	Community Care Network (California-specific)
COB	coordination of benefits (see definition)
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPR	Corporate Process Requirement
DME	durable medical equipment (see definition)
EAP	Employee Assistance Program
EBC	Employee Benefits Committee
EHS	Eckerd Health Services
EOB	explanation of benefits
EPS	Express Pharmacy Services
ERISA	Employee Retirement Income and Security Act
FMLA	Family and Medical Leave Act
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization (see definition)
ICSI	intracellular sperm injection

IP	inpatient
IUD	intrauterine device
LOA	leave of absence
LTD Plan	Long-Term Disability Plan
MPR	Medical Procedure Review
MSN	Medical Specialty Network (see definition)
NAIC	National Association of Insurance Commissioners
PDP	Prescription Drug Program
PPO	Preferred Provider Organization (see definition)
PTPP	Pre-Tax Premium Plan (see definition)
QB	qualified beneficiary
QMCSO	qualified medical child support order
RSA	Reimbursement Spending Account
SPD	Summary Plan Description
TMJ	temporomandibular joint (see definition)
Intermediate PPO	Two Option Medical Plan
United of Omaha Customer Service	Integrated Behavioral Services, United of Omaha's Behavioral Health division
U&C	usual and customary (see definition)
UM	utilization management
UNOS	United Network of Sharing
USERRA	Uniformed Services Employment and Reemployment Rights Act of 1994

Definitions

alcohol and drug abuse — See mental or nervous disorder

alternate payee/recipient — A child or custodial parent who is not a primary insured and who, because of a "qualified medical child support order" (see definition), is entitled to receive a reimbursement directly from the Claims Administrator

child(ren) — Children include:

- the primary insured's own children and legally adopted children
- adopted child (if the placement agreement and/or final adoption papers have been completed and submitted to the Sandia BCSC)
- stepchildren living with the primary insured (stepchildren visiting for the summer are not considered to be living with you)
- child for whom you have legal guardianship
- child, **if** a court decree requires you to provide coverage

See pages 2-4 and 7 for a description of children to be covered by the Intermediate PPO (Class I and Class II dependents).

Claims Administrator — The third party designated by Sandia to receive, process, and pay claims according to the provisions of the Intermediate PPO

coinsurance — Cost-sharing feature by which the Intermediate PPO in-network PPO option, out-of-network Non-PPO option, and out-of-area coverage pay a percentage of the covered charge, and the insured pays the balance of that covered charge

coordination of benefits (COB) — When an insured has medical coverage under other group health plans (including Medicare), Intermediate PPO benefits are reduced so that total combined payments from all plans do not exceed 100% of the highest allowed U&C charges or the lowest negotiated fee

copayment

Cost-sharing feature by which the in-network PPO option pays the remainder of the covered charge after the insured pays his or her portion as either a defined dollar amount or a percentage

covered charge

A medical expense that the insured incurs and that is payable under the terms of the Intermediate PPO

custodial care

Services or supplies, regardless of where or by whom they are provided, that

a. a person without medical skills or background could provide or could be trained to provide; or

b. are provided mainly to help the insured with daily living activities, including (but not limited to)

- walking, getting in and/or out of bed, exercising and moving the insured person;
- bathing, using the toilet, administering enemas, dressing and assisting with any other physical or oral hygiene needs;
- assistance with eating by utensil, tube, or gastrostomy;
- homemaking, such as preparation of meals or special diets, and house cleaning;
- acting as a companion or sitter;
- supervising the administration of medications that can usually be self-administered, including reminders of when to take such medications;

c. provide a protective environment; or

d. are part of a maintenance treatment plan or are not part of an active treatment plan intended to or reasonably expected to improve the insured's sickness, injury, or functional ability; or

e. are provided for the convenience of the insured or the caregiver or are provided because the insured's own home arrangements are not appropriate or adequate.

deductible

Covered charges incurred during a calendar year that the insured must pay in full before the Intermediate PPO reimburses the insured for additional covered charges

detoxification services

A program that provides a structured environment in which the systematic reduction in the amount of toxic agent in the body can be carried through

developmental care

Services or supplies, regardless of where or by whom they are provided, that

a. are provided to an insured who has not previously reached the level of development expected for the insured's age in the following areas of major life activity:
   - intellectual,
   - physical,
   - receptive and expressive language,
   - learning,
   - mobility,
   - self-direction,
   - capacity for independent living,
   - economic self-sufficiency
b. are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to injury or sickness); or
c. are educational in nature.

dual Sandians

Both spouses are employed by Sandia National Laboratories

durable medical equipment (DME)

Equipment determined by United of Omaha to meet the following criteria:

a. is prescribed by a licensed physician,
b. is medically necessary,
c. is not primarily and customarily used for a nonmedical purpose,
d. is designed for prolonged use, and
e. serves a specific therapeutic purpose in the treatment of an injury or sickness.

EAP affiliate

A licensed master's or Ph.D.-level mental health clinician who provides information, assessment, short-term counseling, and referral. An EAP affiliate is under contract to United of Omaha to provide services through the EAP. The EAP affiliate's services are free of cost to employees and their eligible dependents.

EAP counselor

A licensed master's or Ph.D.-level mental health clinician who provides information, assessment, short-term counseling, and referral

emergency

A sickness or injury of such severity that failure to get immediate medical care could put the patient's life in danger or cause serious harm to the bodily functions (see page 6-12). Some examples are apparent heart attack, severe bleeding, loss of consciousness, and obvious fractures. Some examples that are usually **not** emergencies are ear infections, influenza, nausea, or term deliveries.

experimental or investigational

Experimental or investigational drug, device, treatment or procedure means

a. a drug or device that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and that has not been so approved for marketing at the time the drug or device is furnished; or

b. a drug, device, treatment, or procedure that was reviewed and approved (or that is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function, or a drug, device, treatment, or procedure that is used with a patient informed consent document that was reviewed and approved (or that is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function; or

c. a drug, device, treatment, or procedure that reliable evidence shows is the subject of ongoing phase I, II, or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

d. a drug, device, treatment, or procedure for which the prevailing opinion among experts, as shown by reliable evidence, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

(See also "reliable evidence.")

financially dependent persons

Persons who receive greater than 50% of their support from the primary insured

formulary

A list of preferred brand-name drugs that can meet a patient's clinical needs at a lower cost than other brand-name drugs

global charge

The single expense incurred for the combination of all necessary medical services normally furnished by a physician or other covered providers (or multiple physicians or other covered providers) before, during, and after the principal medical service. The global charge will be based on a complete description of the covered medical service rather than a fragmented description of that service. The global charge will not exceed the usual and customary charge allowed by the policy.

The determination of what is included in the global charge will be made by United of Omaha, United of Omaha's medical staff, or a qualified party or entity selected by United of Omaha.

Health Care Reimbursement Spending Account (RSA)

Used to help pay for health care expenses not reimbursed or only partially reimbursed by any medical, dental, vision plan, or other health insurance plan. This account can be used by active employees only.

Health Maintenance Organization (HMO)

An affiliation of health care providers offering health care to enrollees

home health aide services

Include (but are not limited to) helping the insured with

- bathing and care of mouth, skin, and hair;
- bowel and bladder care;
- getting in and out of bed and walking;
- exercises prescribed and taught by appropriate professionals;
- medication ordered by a physician;
- household services essential to the home health care (if the services would be performed if the insured were in a hospital or skilled nursing facility); and
- reporting changes in the insured's condition to the supervising nurse.

hospice

A program provided by a licensed facility or agency that provides home health care, homemaker services, emotional support services, and other service provided to a terminally ill person whose life expectancy is six months or less as certified by the person's physician

hospital

Any of the following facilities that are licensed by the proper authority in the area in which they are located:

- a place that is licensed as a general hospital by the proper authority of the area in which it is located
- a place that
  - is operated for the care and treatment of resident inpatients,
  - has a registered graduate nurse (RN) always on duty,
  - has a laboratory and X-ray facility, and
  - has a place where major surgical operations are performed, or
- a facility that is accredited by the Joint Commission on the Accreditation of Healthcare Organizations, American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities if the function of such facility is primarily of a rehabilitative nature, provided such rehabilitation is specifically for treatment of a physical disability. Such facility need not have major surgical facilities.

When treatment is needed for mental or nervous disorders/ alcohol and drug abuse and/or substance abuse, **hospital** can also mean a place that meets these requirements:

- has rooms for resident inpatients,
- is equipped to treat mental or nervous disorders/alcohol and drug abuse and/or substance abuse,
- has a resident psychiatrist on duty or on call at all times,
- as a regular practice, charges the patient for the expense of confinement, and
- is licensed by the proper authority of the area in which it is located.

Hospital does not include a hospital or institution or part of a hospital or institution that is licensed or used principally as a clinic, convalescent home, rest home, nursing home, home for the aged, halfway house, or board and care facilities.

hospital confinement

A medically necessary hospital stay of 24 consecutive hours or more in any single or multiple departments or parts of a hospital for the purpose of receiving any type of medical service. These requirements apply even if the hospital does not charge for daily room and board. How the hospital classified the stay is irrelevant as well.

Any hospital confinement satisfying this definition will be subject to all contract provisions relating to inpatient hospital services or admissions, including any applicable preadmission review requirements. Hospital stays or services not satisfying this definition will be considered under the contract provisions for outpatient services.

injury

An accidental bodily injury that requires treatment by a physician. It must result in loss independently of sickness and other causes

inpatient

A person who occupies a hospital bed, crib, or bassinet while under observation, care, diagnosis or treatment for at least 24 hours

insured

You and/or your dependents who are covered under the Intermediate PPO. This term is in lieu of "covered participants" as used in ERISA.

Intensive Outpatient Services

A program that provides 9 to 20 hours per week (less than 4 hours per day) of professionally directed evaluation and/or treatment

jaw joint disorder (TMJ) Any misalignment, dysfunction, or other disorder of the jaw joint (or of the complex of muscles, nerves, and tissues related to that joint). It includes temporomandibular joint (TMJ) dysfunction, arthritis, or arthrosis; other craniomandibular joint disorders; and myofascial or orofacial pain syndrome. It does not include a fracture or dislocation that results from an injury.

living with you A person living in your home at least 50% of the year. Stepchildren visiting for the summer are **not** considered to be living with you.

maintenance care Treatment beyond the point where material or significant improvement is to be expected. The treatment results in no measurable or objective improvement. For modality treatments, such as nonsurgical spinal treatment or physical therapy, the treatment provides no evidence of lasting benefit; treatment provides only relief of symptoms.

Medical Director A physician employed, appointed by, or under contract to review quality assurance and utilization review programs, standards, and procedures, and perform any other duties as directed by United of Omaha

medically necessary service A service or supply that is ordered by a physician, the Medical Director, and/or a qualified party or entity selected by United of Omaha, and determined as

a. provided for the diagnosis or direct treatment of an injury or sickness;
b. appropriate and consistent with the symptoms and findings or diagnosis and treatment of the insured's injury or sickness;
c. provided in accordance with generally accepted medical practice on a national basis;
d. the most appropriate supply or level of service that can be provided on a cost-effective basis including, but not limited to, inpatient vs. outpatient care, electric vs. manual wheelchair, surgical vs. medical or other types of care; and
e. allowable under the provisions of the Intermediate PPO as prescribed by the insured's physician or PCP.

Medical Specialty Network (MSN)

A United of Omaha Companies program that provides insureds and their families with access to medical care at some of the most well-known and respected health care institutions in the United States for technologically advanced procedures including organ transplants, bone marrow transplants, and brain/spinal cord injury rehabilitation

Medicare

A federal program administered by the Social Security Administration that provides benefits partially covering the cost of necessary medical care

mental or nervous disorder

Any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a Mental Disorder. Not included in this definition are conditions or diseases specifically excluded from coverage.

morbid obesity

A condition in which an adult has been 100 pounds over normal weight (by United's underwriting standards) for at least 5 years despite documented unsuccessful attempts to reduce under a physician-monitored diet

negotiated fee

A contractual fee agreed to by providers (see "participating providers physician") or facilities and the Claims Administrator for services provided to Intermediate PPO insureds

nonsurgical spinal treatment

Detection or nonsurgical correction (by manual or mechanical means) of a condition of the vertebral column, including

a. distortion,
b. misalignment, or
c. subluxation,

to relieve the effects of nerve interference that results from or relates to such conditions of the vertebral column

out-of-area coverage

Coverage provided for insureds whose address is located outside of an available PPO network

out-of-pocket maximum

The insured's financial responsibility for covered medical expenses **before** the Plan reimburses additional covered charges at 100%, with no deductible, for the remaining portion of that calendar year

outpatient

A person who visits a clinic, emergency room, or health facility and receives health care without being admitted as an overnight patient (under 24-hour stay)

outpatient surgery

Any invasive procedure performed in a hospital or surgical center setting when a patient is confined for a stay of less than 24 consecutive hours

Partial (or Day) Hospitalization

A program that provides covered services to persons who are receiving professionally directed evaluation or treatment and who spend only part of a 24-hour period (but at least four hours per day) or 20 hours per week in a hospital or treatment center.

participating provider

The health care professionals, hospitals, facilities, institutions agencies, and practitioners with whom United of Omaha and CCN contract to provide covered services and supplies to Intermediate PPO insureds

physician

Any of the following licensed practitioners who perform a service payable under the Intermediate PPO

1. a doctor of medicine (MD), osteopathy (DO), podiatry (DPM), or chiropractic (DC);
2. a licensed doctoral, clinical psychologist;
3. a Master's-level counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral, clinical psychologist;
4. a licensed physician's assistant (PA);
5. a licensed nurse practitioner; or
6. where required to cover by law, any other licensed practitioner who:
   (a) is acting within the scope of his/her license; and
   (b) performs a service that is payable under the Intermediate PPO

A physician eligible for reimbursement by this Plan **does not** include a person who lives with you or is part of your family (you; your spouse; or a child, brother, sister, or parent of you or your spouse).

precertification

The process whereby the insured calls the Claims Administrator to obtain prior approval for the medical necessity and appropriateness for services

Preferred Provider Organization (PPO) — A network of physicians and other health care providers who are under contract with United of Omaha to provide services for a negotiated fee

Pre-Tax Premium Plan — A plan that allows employees to pay for premiums on a pre-tax basis

primary insured — The person for whom the coverage is issued, that is, the Sandia employee, retiree, survivor, or the individual who is purchasing temporary continued coverage

primary plan — The Plan that has the legal obligation to pay first when more than one health care plan is involved

provider — See "physician"

qualified beneficiary — An employee, spouse, or dependent covered the day before the qualifying event, to include a child who is born to or placed for adoption with the covered employee during COBRA. Qualified beneficiaries must be given the same rights as similarly situated employees/beneficiaries.

qualified medical child support order — A court-ordered judgment, decree, order, or property settlement agreement in connection with state domestic relation law that either (1) creates or extends the rights of an "alternate payee/recipient" (see definition) to receive the reimbursement from the Plan or (2) enforces certain laws relating to medical child support

reliable evidence — Any published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, treatment, or procedure; or the written, informed consent used by the treating facility or by another facility studying substantially the same drug, device, treatment, or procedure

short-term counseling — For Sandia's EAP, one to eight problem assessment/counseling visits per year. Individuals or dependents/families may access the visits separately if different problems are addressed.

sickness

A disease, disorder, or condition that requires treatment by a physician. For a female member, sickness includes childbirth or pregnancy.

skilled nursing care facility

An institution or that part of an institution that provides convalescent or nursing care and is, or could be, certified as a skilled nursing care facility under Medicare

sound natural teeth

Teeth that

1. are whole or properly restored,
2. are without impairment or periodontal disease; and
3. are not in need of the treatment provided for reasons other than dental injury

specialist

Any physician who is devoted to a medical specialty

subrogation

The Plan's or Claims Administrator's right to recover any Intermediate PPO payments made because of sickness or injury to you or your dependent caused by a third party's wrongful act or for negligence and for which you or your dependent have a right of action or later recovered said payments from the third party

substance abuse

Abuse by the individual of drugs, alcohol, or other chemicals to the point of addiction, which has been diagnosed as an illness by a licensed physician (this is part of the behavioral health benefit) (see also "mental or nervous disorder")

TMJ dysfunction

Temporomandibular joint dysfunction. See "jaw joint disorder."

total disability or totally disabled

Because of an injury or sickness

1. you are completely and continuously unable to perform the material and substantial duties of your regular occupation and are not engaging in any work or occupation for wages or profit; or
2. your dependent is
   a. either physically or mentally unable to perform all of the usual and customary duties and activities (the "normal activities" of a person of the same age and sex who is in good health); and
   b. not engaged in any work or occupation for wages or profit.

urgent care

Medical events that are not life-threatening but require prompt medical attention. Examples of urgent situations are sprains, strains, vomiting, cramps, diarrhea, bumps, bruises, colds, fevers, small lacerations, minor burns, severe stomach pains, swollen glands, rashes, poison ivy, and back pain.

urgent care center

Can be attached to a hospital or be freestanding, staffed by licensed physicians and nurses, and providing health care services

urgent care services

Treatment of a sudden or severe onset of illness or injury

usual and customary (U&C) charges

The global charge for a covered service or supply that is no higher than the 90th percentile of United of Omaha's most currently available prevailing health care charge data. When there is insufficient charge data available for a covered service or supply, the U&C charge will be based on values or amounts established by United of Omaha.

This page intentionally left blank.

Appendix E

Notification of HIPAA Privacy Notice

A federal law, the Health Insurance and Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which is available from the Sandia BCSC.

This Plan, and Sandia Corporation, will not use or further disclose information that is protected by HIPAA ("protected health information") without your written authorization except as necessary for treatment, payment, health plan operations, and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Sandia National Laboratories.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. Privacy notices will be distributed to all current enrollees in the Plan by April 14, 2003, and to new primary participants upon enrollment in the Plan. In addition, a copy of this notice will be available upon request by contacting the Sandia BCSC. If you have questions about the privacy of your health information or you wish to file a complaint under HIPAA, please contact the HIPAA Privacy Officer for the Sandia BCSC.

This page intentionally left blank.

Appendix F

Intermediate PPO Contact Information

Telephone Numbers and Hours of Operation

Function	Telephone Numbers
United Of Omaha	
Customer Service ■ claims questions ■ check eligibility ■ benefit information ■ participating providers ■ precertification ■ case management ■ medical necessity review ■ participating providers	1-800-488-0167 (All sites) 6:00 A.M.–6:00 P.M. (MST) Monday-Friday
On-Site Representative (Bldg. 832 east wing/Rm. 34E)	505-844-0657 8:00 A.M.–4:30 P.M. (MST) Monday–Friday (9/80 schedule) Messages recorded after hours, weekends, and holidays.
On-site Employee Assistance Program (EAP) New Mexico California	 505-845-8085 925-294-2200

Function	Telephone Numbers
Reimbursement Spending Accounts	1-800-446-0113 6:30 A.M.–2:30 P.M. (MST)
EHS Prescription Drug Program	
Insured Services ■ mail order refills ■ information on pharmacy network ■ benefit information	888-249-5041 (toll-free) 6:00 A.M.–9:00 P.M. (MST) Monday–Friday 7:00 A.M.–6:00 P.M. (MST) Saturday 7:00 A.M.–4:00 P.M. (MST) Sunday
Pharmaceutical Questions	888-249-5041 24-hours-a-day service
Sandia National Laboratories	
Benefits Customer Service Center (BCSC), Bldg. 832 east-wing/Rm. 34E ■ enroll/disenroll in Health Plan ■ forms, i.e., claims, others ■ work/family benefits information In California, Bldg. 925/Rms. 127, 102	**New Mexico:** 505-845-BENE (2363) or 1-800-41SANDI (417-2634) then dial 845-BENE (2363) Fax: 505-844-7535 9:00 A.M.–3:00 P.M. (MST) **California:** 510-294-2254/2073 Fax: 510-294-2392 7:30 A.M.–4:00 P.M. (PST)

Obtaining Claim Forms/Envelopes

To obtain Intermediate PPO claim forms, Reimbursement Spending Account claim forms, EPS Mail Service Prescription Enrollment Order Form/Envelope, or a Prescription Drug Program Direct Reimbursement Form (EHS), use any of the following methods:

1. Sandia Line: Dial 845-6789 or if you are calling from outside Albuquerque, first dial 1-800-417-2634 then 845-6789. Press "9" for quick dial codes.
   - Retirees–press "1088" and "#". Follow instructions.
   - Active Employees–press "1284" and "#" for a fax.

2. Web Access:
   The Corporate forms address is
   http://www-irn.sandia.gov/corpdata/corpforms/formhp.html.

To retrieve forms, click on Benefits/Lab News from the menu. Then download the form required; print the form or type in your responses, and print for mailing. The Prescription Drug Program Direct Reimbursement form will not be available on the Web.

3. Sandia Benefits Department: Benefits Customer Service Center, in Albuquerque, Building 832E; or in Livermore, Medical Clinic.

4. Department Secretaries: Secretaries may obtain forms and envelopes from Just-in-Time.

5. Obtain forms from the appropriate Administrator, i.e., United of Omaha, Eckerd, etc.

Sandia Addresses

New Mexico:
Health & Work/Family Benefits
Department 3341, MS 1021
PO Box 5800
Albuquerque, NM 87185

California:
Personnel & Employee Resources
Department 8522, MS 9111
PO Box 969
Livermore, CA 94551-9111

This page intentionally left blank.